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**'Being a smoker': investigating smoking identities
in different socio-economic groups in England**

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PhD thesis

2007

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ABSTRACT

Smoking is strongly linked to disadvantage (Jarvis & Wardle, 1999). Psychological approaches to studying the 'poor smoker' have tended to neglect potentially important 'macro-social' factors. This thesis takes a social psychological approach, focused on social identity (Campbell, 1997). It aims to consider the construction of identities and meaning-systems amongst different socio-economic status groups in England. Two studies were undertaken, representing a mixed methodological approach. In the first study, smokers and non-smokers from higher and lower socio-economic groups were given a conceptual map task to capture their spontaneous associations with the topic. This was followed by an in-depth interview. A thematic analysis showed that smokers were identified as 'unhealthy, stressed out and addicted'. They were also identified with 'Other' already stigmatised groups such as the old, the young and working-class groups. Non-smokers emphasised a moral discourse surrounding smoking to draw boundaries between themselves and 'bad' smokers. Higher SES smokers tended to distance themselves from the negative dimensions of smoking identities, whereas lower SES tended to internalise them. The second study was a Q-methodological one, comprising a sample of smokers from different SES groups. A six-factor model of 'smoking identities' was generated. Three identities oriented around a biomedical model of smoking as an addictive health risk. The other three reflected alternative or paradoxical constructions of smoking based on pleasure, freedom and the rights of smokers. It is concluded that taking into account smoking identities and the conceptual understandings underlying them offers the opportunity to locate health promotion where the audience is thinking (Joffe, 2002). This is particularly important when targeting lower SES smokers.

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CHAPTER ONE:

INTRODUCTION

'Smoking is acquiring a new social profile, as a habit it follows the contours of social disadvantage'

Hilary Graham (Marsh and McKay, 1994, pp 24)

1.1 Outline of this chapter

This chapter aims to establish why the topic of class dominates the research agenda in the psychology of smoking¹. Drawing primarily on epidemiological and psychological studies on the prevalence and predictors of smoking, one theme emerges: class is intimately linked with smoking. This link has changed considerably over the past two hundred years. In the 19th century, smoking was the hobby of the middle-class gentleman, in the inter-war period it was the habit of the masses and in the late 20th and early 21st century, it has become the addiction of the working class and the poor (Hilton 2000). This chapter therefore serves to locate this thesis within the current investigations into the smoking 'gap' between advantaged and disadvantaged (Marsh and McKay 1994; Jarvis 1997; Jarvis and Wardle 1999). It also presents a rationale for the overall aim of this thesis as an exploration of the class-smoking link.

1.2 Smoking and the class 'gap'

1.2.1 Measures of disadvantage and smoking

The UK is experiencing what is termed a 'mature epidemic' of smoking (Jarvis, 1997). Its maturity is characterised in several ways. In contrast to many other countries, the prevalence of smoking in the UK appears to have peaked. Public policies and public opinion generally favour non-smoking and the majority (70%) of smokers are concerned with quitting (Jarvis, 1997). Smoking rates have been declining in the UK

over the last 20 years. There are, however, annual fluctuations amongst certain social groups, for example, amongst teenage girls regular smoking rose from 10% in 1999 to 12% in 2000 (ONS, 2002). However, the overall rates have been stable or falling slightly over the last few years (Lader & Meltzer, 2004). Currently approximately 1 in 4 adults is a regular smoker², 28% of men and 24% of women (Lader & Meltzer, 2004). Smoking peaked around the end of the Second World War. Sixty-five percent of men and 40% of women smoked in 1948 (Royal College of Physicians, 2000). The general trend, therefore, is one of decline.

However, smoking rates have not declined equally across social groups. Smoking rates differ dramatically according to class or socio-economic status (SES). Current figures from the Omnibus Survey suggest that only 16% of men and 15% of women in managerial or professional jobs smoke, whereas the rates are 36% for men and 34% for women in routine and manual work (Lader & Meltzer, 2004). Multiple disadvantages multiply the rates. Bennett, Jarvis, Rowlands, Singleton and Haselden (1996) estimate the rates of smoking amongst currently unemployed, unskilled, manual workers, living in rented crowded homes to be 75%, compared with only 15% amongst professional owner occupiers with degree-level education and a car. Extremely disadvantaged people have even higher rates. Homeless people have a smoking rate of 80-90% (Gill, Meltzer, Hinds and Pettigrew, 1996).

The link with smoking is found, whichever measure of deprivation is taken. In an influential piece of research, Marsh and McKay (1994) showed that within a low income group, being a manual worker, having a poor education, being in receipt of means tested or social security benefit, living in social housing, being a lone parent and

² Current regular smokers are classified as those who smoke more than 1 a day.

co-habiting all significantly and independently predict who smokes. Residential area deprivation also independently predicts higher smoking rates above socio-economic status (Sholaimi, Luben, Wareham et al., 2003). This has led Jarvis and Wardle (1999) to conclude 'this illustrates what might be proposed as a general law of Western industrialised society; namely that any marker of disadvantage that can be envisaged or measured, whether personal, material or cultural, is likely to have an independent association with cigarette smoking' (Jarvis & Wardle, 1999, pp. 242).

This disparity in smoking rates between classes did not exist in the recent past. As indicated in the introduction, smoking in the Victorian period was primarily the preserve of middle-class men. It was these liberal bourgeois gentlemen who enjoyed both the money and the social status to smoke luxury hand-rolled cigars. The introduction of the Bonsack machine in 1883 led the way to mass market production of cigarettes in the early twentieth century. The drop in price and mass availability, coupled with social change, led to smoking being accessible to other social groups, such as women and manual workers. By the mid to late 1940's smoking rates peaked at 80% of men and 40% of women. These high rates were similar across all class groups; smoking had become democratised (Hilton, 2000). However, since the Second World War, smoking has been associated increasingly with social disadvantage. The highest rates of smoking are now found amongst manual workers and the unemployed of both sexes. The smoking 'gap' between classes is therefore a late twentieth and early twenty-first century phenomenon that looks set to continue. The issue, therefore, is to identify what has caused the gap to open up.

1.2.2 Smoking trajectories and disadvantaged life-courses

The notion of ‘smoking trajectories’ stems from the idea that adult smoking status is influenced not just by current socio-economic circumstances, but by ‘longer term biographies of disadvantage’ which stem back into childhood and adolescence (Graham, Inskip, Francis and Harman, 2006, p. ii7). Each stage in the smoking career, from initiation to regular smoking to quitting, has been found to have a relationship with socio-economic status (e.g. Gilman, Abrams & Buka, 2003; Jefferis, Power, Graham and Manor, 2004a). This short section reviews some of the epidemiological evidence linking smoking status to SES throughout the life-trajectory, as a backdrop to considering the development of smoking identities through the life-course in Chapter Three.

The account of smoking trajectories takes place against the backdrop of a wider narrative concerning the ‘slow’ and ‘fast’ tracks to adulthood taken by adolescents from different SES groups (e.g. Jones, 2002, in Graham & McDermott, 2005, p. 24.) The ‘slow’ lane from adolescent to adulthood is taken predominantly by middle-class or higher SES individuals, who stay in education longer and tend to defer marriage and child-bearing. The ‘fast’ lane is populated with young people from poorer backgrounds, where there is little orderly progression from school to university to career to marriage and children. Poorer young people are more likely to move from periods of training into low-paid work, unemployment and to further training. They rarely move up the ladder, moving from low-paid to low-paid job. For girls, many have children young and outside stable relationships.

This account has been critiqued for perceiving advantaged trajectories to be the norm and those associated with disadvantaged as found wanting (e.g. Fergusson, 2004).

However, it is important to note that smoking trajectories are embedded within these diverging paths of more and less advantage throughout the life-course. For example, qualitative research with mid-to-late adolescents has suggested that school-leavers who become unemployed may quickly develop entrenched smoking patterns in relation to their despondency and boredom than for those who follow alternative, more advantageous, trajectories into work or higher education (Wiltshire, Amos, Haw and McNeill, 2005). This is given some support by quantitative research which associates unemployment with higher smoking rates (Mathers & Schofield, 1998), although other research has not confirmed this link (Jeffries et al., 2004a). The ‘fast’ pathway also includes early parenthood, which in turn predicts persistent smoking behaviour (Jeffries et al., 2004a). Education is another major pathway through which childhood SES exerts an influence on smoking in adulthood; those with lower educational qualifications and who leave school earlier are more likely to smoke, be heavy smokers and less likely to quit smoking (e.g. Graham & Der, 1999a). The effect may be bi-directional; those who are regular or heavy smokers are likely to be less mobile in terms of their work-related opportunities (Jeffries et al., 2004a).

The age of initiation is an important factor in determining future smoking trajectories. Those who start smoking at an early age are more likely than other smokers to smoke for longer and more likely to die prematurely from a smoking-relative illness, given the dose-response relationship between tobacco intake and disease risk. The age of initiation is related to SES (Goddard & Green, 2005). In professional/managerial households, 29% had started smoking before they were 16, whereas in routine and manual households, the rate was 44% (Goddard & Green, 2005). This is problematic as consumption is associated with early initiation; 52% of those smoking more than 20 a day started smoking regularly before they were 16, compared with 30% of those

smoking less than ten a day. This suggests that the early initiation of smoking places those from manual households on a trajectory of smoking in which they are likely to become heavier smokers for longer and which eventually leads to higher smoking related mortality and morbidity.

Another key time point at which smoking trajectories, and thus life-trajectories diverge, is quitting smoking. There is a well-established class difference in quit rates³ or, as it is sometimes termed, ‘smoking cessation’ inequality (Jarvis, 1997; Marsh & McKay, 1994). In the period from 1973 to 1993, for example, smoking cessation rates have more than doubled from 25% to 60% in more affluent groups. In the poorest groups the rate of smoking cessation remained the same, just 10% (Jarvis, 1997). In other words, more than 1 in 2 smokers in social class groups I and II will give up, but only 1 in 10 smokers in social class V will do likewise. Prospective as well as cross-sectional data supports this proposition. An analysis of the British National Child Development Study (NCDS) which follows a cohort of individuals all born in one week in March 1958 shows that at age 33, 36% of more affluent individuals had given up. Only 15% of poorer individuals had done so (Ferri, 1993). This inability to quit means that smokers from lower SES groups are failing to gain from the reduction in tobacco-attributed morbidity and mortality in the same way as their more advantaged contemporaries (Jarvis & Wardle, 1999).

The effect of socio-economic status on life and smoking trajectories may also be accumulative. A prospective study by Gilman et al., (2003) has tracked individuals born

³ Estimating smoking cessation rates is not an exact science as many people who stop briefly may classify themselves as ex-smokers, or ex-smokers may classify themselves as ‘ever’ smokers. The quit ratio is a frequently used and relatively robust indicator, which calculates ex-smokers as a percentage of ever regular smokers (Jarvis, 1997).

between 1959 and 1966 in the US. They found that both adult and parental (childhood) socio-economic status was implicated in smoking trajectories. They focused on three transitional periods: initiation, age of regular use and smoking cessation. They found that lower parental occupation and household poverty were related to the risk of initiation. Both childhood indicators and adult SES were linked by association with the likelihood of regular use, however only maternal education was predictive in a regression analysis. Education conferred protective effects; for each additional year of education, there was a reduction in risk for progression. Finally, they found that adult SES was predictive of smoking cessation, as was childhood poverty in the first seven years, although this was attenuated when both were included in the analysis. Again, each additional year of adult education was related to higher odds of quitting. This leads them to argue that the effects of SES on smoking are cumulative and multiple across the generations.

A similar pattern has been found in the UK. Recent analysis of the NCDS cohort shows persistent smoking in adulthood is associated with both childhood and adulthood socio-economic measures (Jefferis, Power, Graham and Manor, 2004a). The association for men with childhood poverty disappears once adult SES is taken into account. However it continues to exert an independent effect for women. Again, education has an important effect; if the effect of childhood socio-economic circumstances was adjusted by the participant's educational qualifications at 23, then the effect was eliminated, suggesting education is an important mediator between childhood poverty and persistent smoking in adulthood. There was also a gender effect for parental influence on smoking persistence; men were more affected by father's smoking and women by mothers' smoking. They conclude that socio-economic circumstances across the life course

influence smoking persistence in a cumulative relationship and that childhood poverty is particularly influential for the future smoking trajectories of females.

Furthermore, it has been suggested that the social gradient of smoking is widening over time. For example, Doll et al., have found that the gap in smoking rates between classes is much wider at age 35-64 than at age 16-35 (Doll, Peto, Wheatley, Gray and Sutherland, 1994). Jeffries and colleagues have also found the social gradient becoming greater in the NCDS cohort study (Jeffries, Power, Graham and Manor, 2004b). They found that smoking prevalence peaked in this cohort at twenty-three and declined from this age. The odds ratio of current smoking by SES for females is 1.28 on a four-point scale at age at age twenty-three, but higher at 1.41 at age forty-one. A similar pattern of gradient was found for men. This suggests that the social gradients in smoking are becoming more, rather than less marked over time (Jefferis, Power, Graham & Manor, 2004b).

So, what does this epidemiological evidence suggest and what are the implications for this thesis? It suggests that smoking is linked with disadvantaged life-trajectories at different time points such as age of initiation, the move to regular smoking and the disparity between quit rates. Furthermore, it is an inter-generational effect; it is not just current socio-economic disadvantage that predicts smoking, but also maternal poverty in particular. Thus smoking and class should be approached from a 'life-course' perspective, in which socio-economic circumstances are understood to be interwoven with smoking careers from childhood to adulthood. Research with adolescents concerning addiction and habit (Chapter Two) and adolescent identities and smoking (Chapter Three) is considered in this thesis with a view to exploring some of the continuities and discontinuities in the shaping of smoking identities across the life-course.

1.3 The material and health consequences for disadvantaged smokers

The work of Marsh & McKay (1994) clearly articulates one of the reasons there is concern over smoking and disadvantage: it makes the poor poorer. Cigarettes are expensive and are taxed by government as a tool to encourage smoking cessation. Evidence shows that for every increase in tax, there is a small increase in cessation (Marsh & McKay, 1994). As has been indicated already in this chapter, however, this increase in cessation is unlikely to come from more disadvantaged social groups. Being a smoker causes disproportionate hardship if you are already poor (Remler, 2004). Marsh & McKay estimate that couples on income support spend 15% of their entire income on cigarettes. Hardship also increases as smoking increases. On indicators of financial hardship, Marsh & McKay calculate that low income families that smoke report twice as much hardship as low income families that do not. Although Marsh and McKay's research considerably underestimates the role of the black economy in supplying cheap cigarettes, their point highlights that being a smoker is an increasingly expensive habit, whatever class one is from. And the poorer one is, the greater the percentage of one's disposable income will be spent on cigarettes. Poorer groups certainly perceive this financial burden as unfair. Attempts are therefore made to minimise the cost of smoking through activities such as smoking cheap contraband cigarettes. A qualitative paper on this topic shows, for example, that socially deprived smokers characterise cigarette smuggling positively, as a 'necessary service' in the face of 'unfair' government taxation on cigarettes, given their addiction to nicotine (Wiltshire, Bancroft, Amos and Parry, 2001)⁴.

⁴ Wiltshire *et al* (2001) define cigarette smuggling as importing and selling cheap cigarettes from abroad where cigarette tax is much lower. One quarter to one third of cigarettes smoked in the UK are estimated to be smuggled or contraband.

Researchers also point to the disproportionate health burden borne by smokers in general, and by poorer smokers in particular (e.g. Marsh & McKay, 1994; Jarvis, 1997; Jarvis & Wardle, 1999.) It is well-known that smoking is causally linked with numerous diseases, particularly many types of cancer and ischemic heart disease as well as premature mortality (Doll, Peto, Wheatley, Gray & Sutherland, 1994). The current estimate is that 1 in 2 smokers will die prematurely from their habit (Doll et al., 1994), and that one in five deaths are smoking-related (RCP, 2000). Less well known is that the health effects of smoking may be more pronounced in poorer smokers (Blaxter, 1990; Birch, Jerrett & Eyles, 2000; Dorset & Marsh, 1998). Blaxter hypothesises that smoking may impact more greatly on the health of manual workers than non-manual workers due to their already compromised life circumstances (Blaxter, 1990). Poorer smokers are more likely to be exposed to other risks such as unemployment, a greater number of adverse life events and poor quality housing, the health effects of which may interact with smoking. Alternatively, it has been suggested that more advantaged people have relative resistance to the adverse effects of smoking, for example, though better nutrition (Birch, Jerrett & Eyles, 2000). It is becoming increasingly apparent that smoking inflicts greater harm amongst disadvantaged groups (Pampel & Rogers, 2004).

This is clear when one looks at mortality and morbidity rates by social class. Jarvis & Wardle (1999) have estimated the proportion of deaths due to smoking by social class since 1970. Their analysis shows that for men in social classes I and II in 1973, the overall risk of dying in middle age was 36% and one third of those deaths were attributable to tobacco. In 1996 their risk had declined to 21%, with only 4% attributable to cigarettes. In contrast, men in social class V had a risk of 47% of dying in middle age, with a full half attributable to tobacco. In 1996, their risk of dying in middle age had dropped only a little to 43%, with still 19% due to smoking. In other words,

men in social class V are not more likely to die now than they were in 1973, but they have failed to gain from the reduction in tobacco-attributable mortality in the way that more advantaged groups have done. The disadvantaged have not shared in the benefits of the increase in smoking cessation.

Indeed, it has been argued that smoking is a key mechanism through which 'health inequalities' are perpetuated in the UK (e.g. Jarvis, 1997; Marmot & Wilkinson, 1999.) The concept of 'health inequalities' refers to the continuing, and some would argue widening, gap between the morbidity and mortality of those at the top of the social hierarchy and those at the bottom (Wilkinson, 1996; Acheson, 1998). One prevailing hypothesis is that socio-economic differences in health status can largely be explained by the higher prevalence of unhealthy behaviours amongst those of lower socio-economic positions. In other words, poorer people have worse health than wealthier people due to their greater propensity to smoke, drink and eat a less healthy diet. Macintyre (1997), in a summary of this argument, refers to this as the 'hard' form of the argument. The 'soft' form of the argument asserts that health-related individual behaviours do not explain away class differences, but contribute to them. It also contends that the key research question to be examined is why such behaviours are persistently more common in poorer groups in the first place (Macintyre, 1997).

This evidence of health inequalities in general, and smoking inequalities in particular, has moved smoking high up the political agenda (Acheson, 1998). Closing the smoking gap between the classes is seen by the British government as a key tool for reducing health inequalities. The first White Paper on smoking 'Smoking Kills' states this explicitly:

'Our priority will be the need to help the least well-off smokers. Smoking is disproportionately high among the more disadvantaged. If we are to reduce smoking overall, and reduce health inequalities, we must start with the groups who smoke the most'

(The Stationary Office, 1998: 4.20)

Numerous subsequent measures, including the NHS Cancer Plan, the White Papers 'Smoking Kills' (The Stationary Office, 1998) and 'Our Healthier Nation' (The Stationary Office, 1998) and 'Choosing Health' (The Stationary Office, 2004), and the recent National Health Inequalities Targets have been devised to target the smoking-linked class gap. The current Smoking Kills target (The Stationary Office, 2004) is to reduce smoking in adults from 26% to 21% by 2010, and to reduce smoking rates amongst manual groups from 32% in 1998 to 26% in the same time-frame. Local targets to reduce the smoking differential have also been set for the Health Action Zones (HAZ), which are 26 parts of the country that are the most deprived and most unequal in terms of health. Also relevant is the corresponding targeting of 'working-class' young adults by the tobacco companies themselves; they view them as a critical market segment in which to promote the growth of key brands (Barbeau, Leavy-Sperounis and Balbach, 2004).

Current research estimates that only 40% of the variance in health inequalities is accounted for, with smoking being unquestionably the largest identifiable factor in developed nations (Marmot, 1999, Wilkinson, 1996). Traditionally, the impact of 'individual' behavioural factors, such as smoking, have been evaluated against other 'environmental' or 'social' factors such as 'social capital' (Wilkinson, 1996) or air pollution (Marmot, 1999). Increasingly, however, this dichotomous approach is seen as simplistic (Marmot, 1999). To take an example, 'social capital' is defined as community norms, values and cohesion and a sense of belonging (Putnam, 1995). Evidence suggests in some instances that social groups with high social capital have higher health

status. However, it also seems plausible that high social capital could reinforce and perpetuate negative behaviours such as smoking within particular social groups. Smoking could be considered an activity around which poorer groups have strong norms and values. It could also be an activity through which a sense of belonging is produced. Social capital and smoking, therefore, need not be conceptualised as ‘competing’ explanatory factors for health inequalities, but as interactive ones.

Whether or not smoking or other health behaviours can carry the explanatory weight of all health inequality is not the principal concern in this thesis. In terms of physical suffering, it is enough to state that increased smoking prevalence in poorer groups causes proportionally greater smoking-related suffering and smoking-related deaths. Given the current estimate of 1 in 2 will die prematurely from smoking, this disproportionate suffering should not be under-estimated. The concern of this thesis, however, is to move beyond the physical suffering which is sufficiently articulated within epidemiological and structural accounts of class inequalities, to focus on the psychological aspects of the phenomenon.

1.4 Definitions

This thesis will take a group-based social identity approach to examining the smoking ‘gap’ between SES groups. Several definitions are therefore needed, which serve to locate this thesis within the existing literature on smoking and deprivation.

1.4.1 Class/SES

The terms used in the literature to study social gradients in relation to smoking differ. Some studies use the older ‘manual’/‘non-manual’ terminology (Class I and II/Class III, IV and IV) (e.g. Jarvis & Wardle, 1999), others refer to ‘working-class’ and ‘middle-class’ (e.g. Hilton, 2000) and yet others use the terms ‘lower’ and ‘higher socio-

economic status (SES)' (e.g. Hedges & Jarvis, 1998). The lower SES smoker is also variously referred to as the 'poor smoker (e.g. Marsh & McKay; Jarvis & Wardle), the 'disadvantaged' smoker (e.g. Wiltshire, Bancroft, Amos and Parry, 2001) and the 'low income' smoker (e.g. Hedges & Jarvis, 1998). However, the multiplicity of terms used and the indistinctness of their use mean that comparisons between studies can be somewhat difficult. There is also debate about how well the standard measures of SES, which are essentially occupation-based measures, capture the range and degree of disadvantage of certain groups, for example, stay-at-home mothers who do not have a former occupation with which to be classified (Graham & Blackburn, 1998).

In terms of existing qualitative research into lower SES groups and smoking, different studies have looked at different research populations depending on their aims (a fuller review of this literature is provided in 2.2.6). For example, Graham conducted qualitative interviews with white working-class mothers as her population of interest on the basis that smoking is particularly concentrated in these groups (e.g. 1987; 1993a). Measures of individual (or household SES) and housing tenure are used as a basis for making quantitative and qualitative comparisons, for example, between non-smokers and smokers in terms of their disadvantaged housing circumstances or caring responsibilities (e.g. 1993a). Bancroft, Wiltshire, Parry and Amos (2003; also Wiltshire, Bancroft, Parry & Amos, 2003) interviewed disadvantaged male and female smokers aged 25-40 living in an area of poverty, aiming to elucidate the link between understandings of smoking and material context. They specified, therefore, both the area from which their research participants were recruited (two health centres located in disadvantaged areas of Edinburgh with few local amenities) as well as the individual employment status and housing tenure of the participants. For example, in their study, 34% of men were not working, alongside 48% of the women, most of whom were

engaged in full-time childcare. 76% were in social housing. Stead et al., (2001) has taken a social geographical perspective investigating how the geography of disadvantaged areas might contribute to social norms of smoking. He defines his population by area, selecting participants aged 20-45 from three Glasgow communities which have very high DEPCAT (Deprivation index) scores with a smoking prevalence of 56% (Reece et al., 2000).

Finally, although most of the qualitative research on smoking and class has focused on research samples primarily from the low income/disadvantaged population, there have been a few comparative studies, particularly relating to health beliefs, class and smoking. For example, Calnan and Williams (1991) conducted a qualitative study examining the salience of health and general lifestyle (including smoking) in two groups of ten households, middle-class (Class I and II from the older-style Registrar General's occupational measure of social class) and working-class (Class IV and V). Chamberlain & O'Neill (1998) also conducted a qualitative comparative study of the social class differences in health beliefs of smokers in New Zealand. They defined 'high SES' as levels 1 and 2 (professional) and 'low SES' as levels 5 and 6 (semi-skilled and unskilled) according to the Elley-Irving SES indices. All of the qualitative studies outlined here concerning smoking and class are examined in more detail in Section 2.2.6 of the literature review.

In this thesis, I often use the term 'class', 'middle-class' and 'working-class' as it captures the notion of a group with a shared socio-cultural perspective. It also fits theoretically with cultural theories of 'middle-class' values and identities surrounding health, control and fatalism and the corresponding, or contrasting, 'working-class' ones drawn on in Chapter Three (e.g. Crawford, 1997; Blaxter, 1990; d'Houtard & Field, 1984; Pierret, 1983; Calnan, 1989).

However, it is important to note that class is operationalized in the empirical studies in this thesis using the recent National Statistics Socio-Economic Classification (NS-SEC) (Rose & Pevalin, 2001). This brings together the old Registrar General's social class (manual/non-manual) classification which was based on occupation and the Socio-Economic Groups (SEG) classification which is based on life opportunities (Rose & Pevalin, 2001). To take an example, someone in Class 1 (highest SES measure typical of professionals) has a relationship of mutual service with the employer with good career progression and high control in comparison with someone in Class 7 who, as an unskilled labourer, simply works their hours in return for a wage or 'labour contract'. These employment conditions are linked to numerous social outcomes, particularly poor health for those with lower classifications.

The research population here, who were primarily drawn from London and the South-East, is defined using the individual's NS-SEC classification with a median split into 'higher' (Class 1-4) and 'lower' SES (Class 5-8). By creating comparative groups, this allows both the differences and the commonalities in smoking identities across the classes to be considered. The characteristics of the research samples for both the interview study and the Q-sort are described in detail in the Methods Chapter (4).

This section has aimed to consider the definitions of 'class', 'socio-economic status' and 'disadvantage', to outline some of ways in which previous qualitative approaches with low income smokers have defined their research populations and to situate this study broadly within that research. A fuller review of this literature, plus a rationale for the stratification of the research populations in this thesis, is contained in Chapter Two (2.4.1 and 2.4.2). Full details of the research populations for the interview and methodology study are found in Chapter Four.

1.4.2 Identity/identities

The primary aim of this thesis is to investigate the social psychological processes of creating social identities around smoking in different socio-economic groups. This section, therefore, is concerned with definitions of identity. Erickson (1946) divided identity into two parts; 'personal' or individual identity and 'social' identity which is the identity derived from group membership, and the values and emotions which are attached to it. It has been suggested that these are not discrete entities, but rather levels of identity which are multiple and dynamic (Tajfel & Turner, 1986). This thesis is concerned primarily with social identity, which is understood to be something that is created relationally in social contexts according to the situation, rather than a label which is applied in a de-contextualised sense (Tajfel & Turner, 1986). Furthermore, social identity is something which is not neutral, but about which others have strong emotional and value-driven associations; it acts as a signifier both to oneself and to others.

This thesis will investigate at the class gap in smoking rates from the theoretical perspective of social identity. The rationale behind this approach is that the difference in adult smoking rates and smoking trajectories amongst social classes can be considered as group-based phenomenon. It seems appropriate, therefore, to draw on theories which emphasise group-based processing, such as Social Identity Theory (SIT) (Tajfel & Turner, 1986) and stigmatisation theories (Jones, Farina, Hastorf, Markus, Miller et al., 1984; Crawford, 1994) to study it further. SIT/SCT offers a theoretical basis for considering the psychological processes which may occur in the creation of social identities, for example, including in-group processes (such as positive social comparisons) as well as out-group processes (social creativity, dis-identification, perceptions of group variability, accept negative derogation) (for a review, see Brown,

2000). These social identity processes are specifically coded and analysed in the interview study, particularly as they are drawn on differentially by the research participants depending on their smoking status (smokers or non-smokers) and socio-economic status (lower or higher SES).

In this thesis, therefore, there is an assumption that being a smoker, or indeed a non-smoker, can be considered a social identity as membership of a particular social group: thus I refer to 'smoking' identity or, as they may be multiple, identities. This smoking identity is created dynamically in the contexts in which individuals inhabit; it is not always salient or important in all social situations, nor with all people. It also acts as a 'signifier' for others as well as for the self. One of the key aims of this thesis is to consider exactly what 'being a smoker' has come to signify for different social actors, such as smokers or non-smokers, and how this might be affected by their socio-economic location. A considerable body of literature has considered the creation of social identity in relation to adolescent smoking (e.g. Lloyd & Lucas, 1998; Bewley & Bland, 1978; Mitchell & Amos, 1997; Denscombe, 2001) and this is reviewed in detail in Chapter Two. However, less attention has been paid to the creation of smoking identities in relation to adults (Echebarria-Echabe, Fernandez-Guede & Gonzalez-Castro, 1994) particularly in relation to class and socio-economic status which is the focus in this study. It is interesting to note that although the original SCT conceptualises social identity in a dynamic sense, being produced in relation to contexts, work conducted within the social identity paradigm has tended to emphasise generic group processing. This thesis therefore draws on recent re-conceptualizations of SIT/SCT which emphasise context (Campbell, 1997; 2000; 2005). A multiple definition of 'context' is considered in the next section.

1.4.3 Context

As discussed above, the research using social identity theory (SIT) has tended to subscribe to a generalised and de-contextualised notion of identity. However, in this thesis, social identities, and the health practices linked to them, are understood to ‘make sense’ for the people living in complex social contexts (Radley, 1994). Campbell (2005) has identified three interacting dimensions of context in the production of health behaviours. The first is the ‘symbolic’ context, the socio-culturally situated beliefs about the group. The second is the ‘material-political’ context, such as the disadvantaged material conditions of lower SES groups. The third is the ‘organisational’ context, for example, governmental, research and therapeutic communities. This section considers each of these types of context to elucidate how this thesis might explore the creation of smoking identities in relation to them. It will be argued that although there is some attention paid to the material-political and organisational contexts, the main focus of this thesis is on the symbolic ‘macro’ belief-systems which might contextualise ‘being a smoker’ in different socio-economic groups.

The first type of context identified by Campbell (2005) is the one with which this thesis is most concerned: the symbolic belief-systems surrounding the health behaviour in a particular culture. In an interesting theoretical paper on the subject, entitled ‘Smoking-what’s culture got to do with it?’, Nichter (2003) argues that smoking behaviour can be considered as a phenomenon influenced by both structural locations which bind subjective experience (similar to the material/political contexts identified by Campbell) and as the ‘cultural play which involves experimentation with self-image and identity’ (p.139). He argues for a ‘processual’ rendering of culture, where culture is used like an adjective; what is ‘cultural’ about certain behaviour? In particular, he is interested in ‘core cultural values’ and how these might hinder or help smoking behaviour in

particular groups. In relation to ethnic differences in adolescent smoking, for example, he questions whether deep-seated values concerning autonomy might lead to different behaviour concerning boundary-setting (encouraging/limiting) amongst different ethnic groups. He also argues that smoking should not be understood as a symbolic act on its own, but rather as part of a wider set of symbolic behaviour which makes up a cultural statement. Finally, he argues that modernity itself is a context in relation to smoking. He points out that the modern age is one of increasing time compression, greater opportunities for arousal, diminished tolerance for 'boredom' and a consumer society geared towards instant gratification, particularly for youth. He argues that cigarettes, which are instant nicotine-delivery devices understood as an antidote to boredom, may be 'bioculturally' appealing to the young in the context of an adult-oriented political economy. Some research has considered the ways in which the social identities of adolescent and student smokers reflect, embody and re-create cultural values concerning 'coolness', risk-taking and hedonism (McFayden, Amos, Hastings and Parkes, 2003) or personal autonomy (Denscombe, 2001). It is argued here that less attention has been paid to how these socio-cultural values play out in the creation of smoking identities in adults, particularly in relation to class.

Joffe & Staerkle (in press) have argued that social psychology has tended to be more concerned with identifying the social comparison processes which underlie stereotype creation, boundary-drawing and the identification of the 'Other', rather than the actual content. This leads research into social identity/comparison processes to be de-contextualised and to lack reference, and thus relevance, to contemporary culture and values (Joffe & Staerkle, in press). For this reason, this thesis draws theoretically on socio-cultural theories of values, emotions and ideologies, primarily from cultural theory, to offer clues to the potential content of these social psychological processes.

For example, in Chapter Three, I examine in detail the work of Crawford (1977; 1985; 1994) who has argued that in Western culture health has become a primary value which has come to symbolise other desirable Western values linked to the Protestant work-ethic, such as being 'in control', self-discipline and achievement. Due to the feeling of being constantly 'at risk', the middle-classes in particular engage in much boundary-drawing between who is 'good' (the healthy) and who is 'bad' (the unhealthy, the 'risky'). There are also symbolic myths or stories which may be drawn upon in understandings of smoking, such as that of 'addiction' in which the 'addict' is a culturally available illustration of how not to behave (Hammersely & Reid, 2002). Finally, there are a set of symbolic beliefs concerning class, poverty and poor people themselves. For example, research shows that in lay theories of poverty, 'being poor' is associated with fecklessness and lack of forward thinking (Furnham & Gunter, 1984; Ryan, 1971).

Furthermore, these sets of socio-cultural beliefs can be used for ideological functions. As Jovchelovitch in her book 'Knowledge in context' says, 'myth and belief draw power from recognition rather than systematic domination; mythologies and beliefs are powerful because they are recognised by communities and individuals. Yet, they can be easily permeated by the ideological function, when there is a mobilisation of mythologies and beliefs to fulfil purposes of domination' (2007, p.124). Crawford, for example, argues that the pre-eminent valuation of 'health' in contemporary Western society provides a discriminatory function which supports the existing status quo: the middle-classes are healthy, and thus fit to rule and the 'other' groups (such as the working-class, unhealthy, those perceived as 'at risk') are not (Crawford, 1994). In Chapter Six, for example, I consider how the symbolic context in which smoking

identities are created may contribute to the stigmatisation of smokers as a social group, particularly those who are working-class or disadvantaged.

The second 'context' Campbell identifies is the material/structural one. As outlined in the previous section, several qualitative studies have contributed considerably to our understanding of how the material-political context of disadvantage may contribute to the embedded nature of smoking amongst lower SES groups and communities (Graham, 1987; 1993a; Bancroft et al., 2003; Wiltshire et al., 2003; Stead et al., 2001). This literature is analysed in more depth in Chapter 2. This thesis does not set out to study the material contexts of working-class and middle-class smoking in a systematic sense. I do pay some attention, in this thesis, to the material context as understood and reflected by the participants themselves in their discourses. For example, in the interview study, I use an 'episodic' interview format, which aims to uncover the meaning of the behaviour in a variety of life 'domains' (Flick, 1998). Thus the participant is specifically asked about smoking in the work-place, leisure-time, in relationships with family and partners, as well as in their daily lives to contextualise their understandings within their concrete experiences and circumstances (Flick, 1998).

The final context to consider is the 'organisational' or 'institutional' level. In the creation of smoking identities, the institutional level context takes several forms. One is what is loosely termed 'Tobacco Control'. This consists of independently funded lobby groups such as ASH or charities such as the Cancer Research Campaign alongside government funded Department of Health campaigns and public health initiatives concerning smoking cessation. As this introduction has shown, reducing health inequalities, through reducing smoking inequalities is a key policy goal of the current Blair government, and reflected in the number of White papers produced ('Smoking Kills' (The Stationary Office, 1998); 'Our Healthier Nation' (The Stationary Office,

1998); 'Choosing Health' (The Stationary Office, 2004)) which set out specific targets for reducing smoking in lower SES groups. The government is also a contextual actor through legislation, such as the current Bill to ban smoking in enclosed public spaces which will take effect on July 1st 2007. Governmental public health campaigns, legislation and treatment programmes are particularly important in elucidating the link between scientific and lay representations of risks, such as smoking (Joffe, 1999). They represent a widely seen 'central, official position which crystallises what has been deemed a desirable message in the public health policy realm' (p.51). As such, they set the tone of the future debate. Researchers are also institutional actors; for example the debate over whether smoking should be defined as a serious nicotine addiction (e.g. RCP, 2000), or whether such the construction of smoking as addiction leaves individuals feeling powerless (e.g. Gillies & Willig, 1997) is a case in point. Finally, one cannot consider the institutional context of smoking without considering the tobacco companies. For example, as detailed earlier in this section, working-class young adults are the target market of tobacco companies who perceive them as a key market segment (Barbeau., et al, 2004).

Much of this scientific thinking and research, as well as public health policy, are communicated through the mass media which represents a key mediator in this situation. Joffe (1999) has argued that although the mass media do not dictate thinking about a risk in a passive sense, they can constrain the meanings available to lay people which they then negotiate in relation to their own social identities. Penn (1998), for example, has argued that the adverts on cigarette packets show a systematic move to a medicalized understanding of smoking. McFayden, Amos, Hastings and Parkes (2003) examined a sample of the smoking imagery in contemporary youth magazines, and students' reactions to it. They suggest that although students may reject 'obvious' pro-

smoking messages, they embrace more subtle and sophisticated smoking images that are found in newer types of lifestyle magazines. Furthermore, the messages underlying many of the pro-smoking images concerning hedonism, risk-taking and not being politically correct, particularly in 'laddish' men's magazines, are ones which feed into a student identity and lifestyle in which it then becomes natural and normative to be a smoker.

This thesis does not set out to systematically study the organisational/institutional contexts nor the mass media. Rather the focus is on the understandings of lay people, smokers and non-smokers from different socio-economic groups, who may, of course, have perceptions of these organisations, and their acts themselves. However, the institutional backdrop is considered in the introduction chapters (1,2,3) and discussions of the findings where relevant, particularly insofar as it embodies or promotes certain symbolic beliefs concerning smoking. For example in Chapter Six, the institutional backdrop of stigmatisation of smokers in England is considered in the light of the interview findings. Similarly, in Chapter Seven, on addiction and habit, I reflect on the incorporation of 'hard drug' terminology into research reported in the media concerning smoking as an addiction.

Finally, it must be pointed out that the three 'contexts' discussed here are, of course, linked. For example, a professional higher SES individual may work in a particular material context, such as a work-place with designated smoking areas, thus locating the worker spatially as 'Other'. This higher SES smoker also has to negotiate, as a psycho-social level, a set of cultural beliefs and values concerning 'professional' behaviour and forge his or her own identity in relation to them. Furthermore, these socio-cultural worlds are embedded in institutional contexts, such as governmental legislation on work-place smoking. Although the research presented in this thesis primarily focuses on

the 'symbolic' level of context as it presents in the thinking of participants, it is also understood to be embedded at the material and institutional levels.

1.5 Conclusion

As Jarvis and Wardle state 'an emerging phenomenon of the utmost significance over the past two decades has been the increasing association of smoking with markers of social disadvantage' (Jarvis & Wardle, 1999, pp.154). These socio-economic markers of disadvantage have been found to be associated with smoking throughout the life-course, from parental smoking, through to first initiation, the move to regular smoking, heavy smoking in adulthood and quit rates. They are thus intimately linked with the different socio-economic pathways or trajectories of disadvantaged and advantaged groups. Given the group-based nature of the class-smoking 'gap', this thesis aims to use a theoretically-driven social identity approach to investigate this phenomenon. It will aim to explore the adult smoking identities of the research participants in relation to both their smoking status (smokers or non-smokers) and their social class (lower or higher SES). These smoking identities are understood to be created within three inter-related contexts; the material/structural, the institutional and the symbolic. This thesis will focus on how the social psychological creation of smoking identities might evidence symbolic beliefs/values, and to tease out some of the potential implications of this.

CHAPTER TWO:

LITERATURE REVIEW

2.1 Introduction

The last chapter established the phenomenon of smoking ‘gap’ between the classes. This chapter outlines and critiques mainstream psychology’s theorisation of the phenomenon. Although the psychological literature on smoking is vast, three major strands are identifiable. The first, deriving primarily from clinical and applied psychology is a biomedical addiction-based approach, which conceptualises the smoker as an ‘addict’ at the mercy of ‘habit’ (e.g. Pomerleau & Pomerleau, 1984; 1989). The second, deriving primarily from social and health psychology, is what is termed the ‘Knowledge-Attitudes-Belief’ approach, as typified by the Theory of Planned Behaviour and Health Belief Model. This literature conceptualises the smoker as a rational individual weighing up their risk and vulnerability to ill-health. The third strand, deriving from the health inequalities literature, understands the disadvantaged smoker as someone who ‘copes’ by smoking through no choice of their own in the face of intolerable stress and hardship caused by material poverty (e.g. Graham, 1987; 1993a; Graham & Blackburn, 1998).

It will be argued that the first two psychological approaches offer a primarily individualist account of smoking that leads to difficulties in accounting for the class/smoking link. Although some reference is made to the importance of ‘social factors’, they are considerably under-theorized. ‘Social’ in these approaches refers to the immediate social context of the smoker, such as the family, peers, or area deprivation. Scant attention is paid to the norms and meaning systems present in the wider ‘macro-social’ context (Joffe, 1996) that people draw on to make sense of themselves as a smoker. The work of Graham takes account of the structural context of

poverty, but may imply a faulty causality in material hardship given that not all poor people smoke. It will be concluded that a psycho-social approach, which emphasizes meanings, norms and identities that are shared as a result of being similarly positioned in the social world, will be used to investigate class and smoking.

2.2 Addiction models of smoking

'Were it not for nicotine people would be no more inclined to smoke than they are to blow bubbles'

(Russell, 1974, pp.14)

2.2.1 Introduction to addiction models of smoking

Addiction is arguably the primary characterization of smoking at present for health psychologists and other health professionals. The acceptance of smoking as an addiction, however, is a relatively new and controversial state of affairs. Tobacco's habit forming properties had been noted as long ago as 1610 by Francis Bacon who observed that the habit was very difficult to give up (Royal College of Physicians (RCP), 2000). However, the major breakthrough in acceptance was the classification of nicotine as an addictive substance in the US Department of Health Surgeon General's Report in 1988 (DHHS, 1998) following decades of resistance by tobacco companies. The RCP Report (2000) states the official position of the UK medical establishment clearly:

In all areas of policy making and management of public health, nicotine delivered rapidly to the brain in tobacco smoke should be regarded as a powerfully addictive drug on a par with heroin and cocaine, and tobacco products should be recognized as nicotine delivery systems'

(RCP, 2000, p. 106)

This section looks at the existence of 'addiction' models in psychology and considers their relevance for class differences in smoking. It will be argued that the concept of addiction inherent in these models, which is primarily medical and individualistic, takes one so far but no further in the search to understand class differences in smoking. In

particular, they leave little theoretical space to consider the important psycho-social factors implicated in such class differences.

2.2.2 *A brief history of the concept of 'addiction'*

There is considerable controversy over what constitutes an 'addiction'. As the Royal College of Physicians report into nicotine addiction states, the meaning and use of words like 'drug', 'addict' and 'addiction' reflects changing societal perceptions rather than offering definitions of fixed objective entities. Currently, the World Health Organisation, the American Psychiatric Association and Royal College of Physicians define an addiction as 'a situation in which a drug or stimulus has unreasonably come to control behaviour' (RCP, 2000, p.p. 21). It is interesting to note that this definition puts irrationality and lack of freedom at the heart of what it means to be addicted. The 'addict' is defined as someone that has lost those qualities that are deemed essentially human in a post-Enlightenment era: rationality and free will.

That smoking should be considered a drug addiction at all is a recent development, unlike other substances such as opium, cocaine and alcohol, which have much longer histories of being considered addictive drugs. Ogden (1997) divides models of health behaviours into three types: moral (behaviour as moral laxity), medical (behaviour as disease/illness) and social (behaviour as socially learned). Opium and alcohol were the subject of 'disease' models of 'inebriety' as early as the eighteenth and nineteenth centuries. These models also had moral dimensions, however, and were considered 'diseases of the will' (RCP, 2000, p. 89). After World War II, illegal drug and alcohol abuse was classified primarily as an 'addiction' or 'dependency' that required medical attention. The increasingly dominant traditions of psychology and psychiatry were seen as the appropriate agencies to provide such treatment. On the other hand, smoking did not appear to produce a state of 'inebriation', and so was not considered within a disease

model until the 1950's and 60's (RCP, 2000). The primary discourse around smoking in the 19th and first half of the 20th century was the debate between people's right to clean air and the liberty of smokers to indulge their 'hobby' (Hilton, 2000). Even Doll and Hill's epidemiological work, which established a link between smoking and various illnesses such as lung cancer (e.g. Doll and Hill, 1950), did little to shift the essentially libertarian discourse which maintained that smoking should be characterised as a balance between the free choice of adults regarding their vices and the need to offer public health information on its dangers (Hilton, 2000).

The shift to conceptualising smoking as an 'addiction' which might limit free choice occurred in the late 60's and early 1970's. The first two Royal College of Physicians Reports on smoking stated that nicotine might keep smokers addicted (RCP, 1962; 1971). Research scientists from within tobacco companies as well as academic institutions developed techniques that showed them that smokers' smoke inhalation was related to controlling their nicotine levels. However, this was primarily a pharmacological conceptualisation of smoking that did not influence public consciousness or, for that matter, the psychological literature to any great degree. Psychology, from the 1970's onwards, tended to view smoking, as with other addictions, in terms of a 'social learning' model (Ogden, 1997). This orientation, typified by the work of Eiser, emphasised the socially learned aspects of the behaviour (Eiser, 1985). Several processes were theorised to occur. One was classical conditioning, where an unconditioned stimulus (taking a break at work) with an unconditioned response (relaxation) is paired with a conditioned stimulus (smoking) to produce a conditioned response (relaxation). In this example, smoking becomes associated with taking a break at work to relax. Both internal (e.g. mood) and external (e.g. situation) cues can be paired with the conditioned stimulus. Smoking therefore becomes associated with certain moods, emotions and places. Other processes include

modelling/observational learning (e.g. seeing others use cigarettes for weight control) and operant conditioning, where the probability of smoking is increased by positive reinforcement (e.g. feelings of social acceptance or confidence) and negative reinforcement (e.g. removal of withdrawal symptoms). The social learning approach in psychology re-characterised smoking as an 'addictive behaviour' which anyone could acquire, rather than a 'disease' or 'illness' inherent in specific individuals.

However, since the 1980's the dominant model of smoking has been that derived from medicine. This is primarily due to extensive biomedical nicotine research, which confirmed that nicotine is an addictive substance with an established withdrawal syndrome, which can be reduced by Nicotine Replacement Therapy (NRT) (DHHS, 1988). In Britain, the most recent Royal College of Physician's Report (2000) endorsed the concept of 'nicotine addiction', arguing that nicotine's addictive properties are on a par with 'hard' drugs such as heroin. The current Health Education Authority guidelines state that treatment of smoking should follow a 'nicotine-withdrawal' model, whereby the 'addict' is weaned off their nicotine gradually using increasingly lower doses of NRT product (West, McNeill & Raw, 2000). The psychological literature, as with popular culture (Berridge, 1999), has been heavily influenced by this medical model. Current psychological models (e.g. Pomerleau and Pomerleau, 1984; 1989) place pharmacological addiction to nicotine at the heart of their explanations of smoking. They also draw to a lesser extent on older psychological traditions, particularly on the idea of 'conditioning' from social learning theory. These psychological models are now considered.

2.2.3 *Current psychological models of smoking as an addiction*

Nicotine is the primary substance thought to make smoking addictive. Smoking delivers a rapid dose of nicotine to receptors in the brain, taking just 10-19 seconds to produce a

'hit' of nicotine. Early psychological theories accounted for the addictive properties of smoking by referring to the physiologically rewarding properties of nicotine alone. The nicotine fixed-effect theory (Hall, Rappaport & Hopkins 1973), for example, states that nicotine stimulates reward centres in the nervous system, thus providing a 'reward' which encourages repeated cigarette use. This theory fails to explain why many smokers relapse and go back to smoking months or years after their last 'hit' of nicotine. Newer psychological theories combine knowledge about the neurobiological processing of nicotine in relation to psychological effects, primarily mood states, reported after nicotine consumption.

The theory of Pomerleau and Pomerleau (1984, 1989) is particularly influential. It posits that smoking is a neuroregulator. This may explain why it is so difficult for people to stop smoking permanently, as well as why smoking is addictive on a daily basis. It is theorised that when nicotine reaches the brain, it mimics a brain chemical called 'acetylcholine' (ACh) and activates neuronal receptors which normally respond to ACh. These are known as nicotinic cholinergic receptors (NACHR's). It hijacks many of these receptors and causes the release of neurotransmitters, in particular dopamine and noradrenaline. Dopamine in the nucleus acumben is a characteristic effect of all drugs of dependence, and is thought to be central to the psychological *positive* rewarding effect of drugs. Noradrenaline release is associated with improved alertness, concentration and memory. Thus the smoker receives positive reinforcement, and is motivated to repeat the behaviour. Over time, these temporary improvements in performance or affect are also associated with many internal and external cues (such as places, alcohol, and food), which stimulate the desire to smoke.

Regular smoking leads to a tolerance of nicotine and a 'normalisation' in dopamine and noradrenergic activity. The brain is used to this level of nicotine, creates more nicotine

receptors, and needs it to maintain normal levels of mood and functioning. When this nicotine is stopped, either through long breaks between cigarettes, or through giving up, a state of nicotine deprivation ensues. This drop in levels of dopamine, noradrenaline and other neurotransmitters is thought to lead to a 'cigarette withdrawal syndrome'. Typical psychological symptoms include poor concentration, irritability, depression, light-headedness, restlessness, disturbed sleep, and most notably, craving to smoke. The smoker is often driven to nicotine use to relieve the symptoms, which constitutes a *negative* reinforcement of the behaviour. Thus smoking is both positively and negatively reinforcing behaviour, providing rewards in terms of mood enhancement as well as avoiding withdrawals. Ex-smokers are theorised to return to smoking as they have learnt that smoking, at least, temporarily represents a coping strategy. Smoking rates amongst those with clinical depression are high and this is theorised to be a result of the shared neural substrate pathways which are modified by both smoking and depression (Quattrock & Baird, 2000). It is argued that it is particularly difficult for depressed people to quit smoking as smoking may mitigate their depressive symptoms as a form of self-medication (Quattrock & Baird, 2000).

Addiction models may be hard pressed to explain why not all children or teenagers who try smoking become regular smokers. Russell (1974) has argued for an 'exposure' model of smoking development. 'Tolerance' to nicotine is envisaged to take place gradually over time for all individuals. Smoking is initially prompted by factors other than addiction, but later use results from dependency. Alternatively, a 'sensitivity' model has been proposed in which the sensitivity to nicotine is envisaged as individually variable (Pomerleau, Collins, Shiffman and Pomerleau, 1993). Some individuals have high innate sensitivity to nicotine that provides them with more intensively rewarding effects. These people are argued to quickly develop tolerance and dependence on nicotine. Others who do not have this sensitivity may try smoking or

smoke irregularly but are unlikely to become dependent. This innate variability has been linked most recently to genetic differences (Pianezza, Sellers & Tynedale, 1998). One gene, CYP2A6, is thought to be the primary gene involved in the metabolising of nicotine to cotinine, and thus in the regulation of dopamine and other neurotransmitters. People who have the gene metabolise nicotine faster than those who do not. They may be more likely to smoke more cigarettes, less likely to stop and may have increased risk of smoking-related illness as a consequence.

The model of nicotine as a neuroregulator has become the pre-eminent model of smoking addiction. However, certain aspects of the model have been questioned, particularly the suggestion that nicotine has mood enhancing effects. Studies using placebo-controlled, double blind conditions have consistently been unable to replicate this finding (for a review see Gilbert & Wesler, 1989; Heishman, 1998). It has been argued, therefore, that the psychological effect of smoking is solely one of negative mood-relieving, rather than to gain positive reward (Hughes, 1992; Waters, Jarvis and Sutton, 1998).

There is also considerable debate over when dependency occurs between experimentation and regular smoking. It has been argued that smoking just a few cigarettes as a teenager causes physiological dependency and leads to regular smoking (Russell, 1974). More recent studies suggest one-third to one-half of teenagers who experiment with trying smoking go on to become regular smokers (McNeill, 1991). This rate of uptake far outstrips any other drug, even 'known' high addiction drugs such as crack cocaine (Anthony, Warner & Kessler, 1994).

Smoking dependency is assessed by several criteria. A common criterion of non-dependency is smokers who smoke less than 5 a day for not more than 4 days a week over a long period. More than 80% of smokers fall outside this definition of non-

dependency (Owen, Kent, Wakefield & Roberts, 1995). Other estimates put the number of dependent smokers much higher, at 95% (Shiffman, 1991). Another measure of dependency is how soon a smoker smokes the first cigarette of the day. Studies have shown that 64% of adult and 46% of teenage regular smokers have their first cigarette in the first hour after waking (Barton, 1998). Nicotine addiction in adults can also be argued to meet the criteria of substance dependence according to the Diagnostic and Statistical Manual of Mental Disorders (DSM III, IIIR and IV) of the American Psychiatric Association and the International Classification of Diseases (ICD-10) of the World Health Organisation (RCP, 2000). Hughes (1992) reports that 90% of adult male smokers in a sample of 1006 fulfilled the criteria for dependence given in DSM III.

2.2.4 How the addiction model accounts for class differences in smoking

Whatever the measure of dependency studies, smoking addiction theorists agree that the vast majority of smokers are addicted. It is arguable, therefore, that addiction models offer an explanation of *all* smoking behaviour. As a consequence, accounting for differences in smoking behaviour between social groups has perhaps not been the primary focus of their theoretical models. This is surprising given the considerable attention paid to the 'poor smoker' phenomenon as outlined in Chapter One.

The primary way in which addiction models account for class differences is by arguing that poorer groups are more addicted than higher SES groups. There is some evidence that dependence varies by class. Looking at consumption levels as a measure of dependence, a recent reanalysis of the 1997-1998 Health and Lifestyle Survey (HEA, 1998) shows that cigarette consumption patterns differ between non-manual and manual workers. Forty-seven percent of smokers in the manual worker category smoke more than 20 a day, whereas only 39% of smokers in the non-manual category do the same, a statistically significant difference. Cotinine (a metabolite of nicotine) measures show a

similar association between deprivation and dependence. The average intake of nicotine is nearly 50% higher in the most deprived group compared with the most affluent group in a sample of smokers from the Health Survey for England in 1993 (Bennett, Dodd, Flatley, Freeth and Bolling, 1995). Certain demographic clusters also have particularly high consumption rates (HEA, 1998). Heavy smokers (more than 20+ a day) are more likely to be men, manual workers, living in the North of England, or living in low income families. Forty-six percent of people in young low-income families smoke more than 20 a day, whereas only 28% of those in young educated groups have a similar level of consumption.

Dependence may also start earlier in lower income groups. Cotinine samples from the Health Survey for England 1996-97 from young people aged 14-24 shows lower income groups have higher levels of cotinine than higher income groups, although it is not clear these are at the level that would constitute dependence (Hedges & Jarvis, 1998). It shows, however, that even in younger groups, lower income teenagers are taking in more nicotine than higher income teenagers. This suggests that their likelihood of becoming addicted to nicotine in adulthood is higher, if not already established.

Nicotine consumption is linearly related to quit rates. Ferri (1993), for example, shows that in the NCDS cohort, 44% of the lightest smokers had given up at age 33, compared with only 17% of heavy smokers. Nicotine dependence has been shown to be an important determinant of ease of quitting (Jarvis & Wardle, 1999). As such, the greater level of addiction in lower income groups is posited as the explanatory factor in the lower cessation rate amongst these groups.

2.2.5 *A critique of the bio-medical addiction approach to class differences*

The addiction account is quite fatalistic in its tone. Children and adolescents are theorised to become rapidly addicted to nicotine, after just a few cigarettes and up to 95% of smokers are considered to be addicted (e.g. Benowitz, 2001). Emphasis is placed on the highly addictive nature of nicotine, with the implication being that once addicted; it is very hard if not impossible to give up. The fatalism inherent in addiction theory, however, makes it even harder to explain class differences in smoking cessation rates.

Firstly, although smoking is undoubtedly addictive, like all addictions, it can be conquered. Although a greater number of poorer smokers (8% more) are classified as heavily dependent (HEA, 1998), it seems implausible that this alone could account for the much greater difference in cessation rates between the classes (50% amongst professional groups as opposed to 10% amongst social class V). Given the assumption that the vast majority of smokers are addicted, it seems more likely that all smokers find quitting difficult, but poorer smokers find it more difficult over and above their greater dependency on nicotine. Evidence from prospective studies of smoking cessation supports this premise. These studies show that although nicotine dependency is a significant factor in smoking cessation, social factors such as household smoking and divorced/marital status account for more variance in smoking cessation (Ferri, 1993). This suggests that researchers need to consider why poor smokers find it so much harder to give up, over and above any addiction to nicotine.

Secondly, attempts to link individual genetic susceptibility (a 'predisposition' towards addiction) to nicotine dependency become problematic in the face of class differences. At the time of writing, no papers have been published to show how individual genetic differences might explain class differences in smoking rates. One might speculate that

such a hypothesis might be that poorer groups possess a greater percentage of individuals with the 'smoking' gene, given rates of 70% smokers in the most disadvantaged groups (Bennet *et al.*, 1996). However, on closer examination this hypothesis is less plausible. There is considerable permeability and mobility between socio-economic groups, so any such gene is unlikely to appear in such high concentrations amongst poorer groups and so rarely in higher socio-economic groups. It would require a considerably high level of selective breeding (smokers only marrying smokers) to attain this differential. Secondly, even if genetic explanations were able to account for the cross-sectional findings of class differences in smoking rates, it seems impossible for them to explain the dramatic and rapid change in smoking cessation patterns since World War II, or even since the 1970's. Changes in genetic makeup of socio-economic groups are unlikely to occur so rapidly.

Thirdly, even if it is accepted that class differences in smoking are solely due to greater dependency, this hypothesis begs an important question: why do poorer smokers become more heavily addicted in the first place? As shown in Chapter One, rates of smoking experimentation and initiation are much the same across class groups. Jarvis and Wardle put this succinctly, 'that nicotine is a powerful drug of addiction no doubt has much to do with this state of affairs, but we need to move beyond this to ask why it is that the poor are particularly drawn to this drug' (Jarvis and Wardle, 1999, p. 247). It is not argued here that dependence on nicotine or genetic factors do not explain class differences in smoking at all. Clearly, there is good evidence that nicotine does create a physiological and psychological dependence in smokers which is associated with inability to quit. Genetic factors may be similarly implicated. The charge is rather that these are not sufficient or complete explanations of the psychology of smoking and are particularly weak as explanations of the psychology of class differences in smoking behaviour.

Furthermore, it can be argued that the inadequacy of smoking addiction models in explaining class differences results from the assumptions on which they rest. Penn (1996) argues that in our society smoking has been substantially medicalized. Medicalization means 'defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it (Conrad & Schneider, 1992, p. 256). Addiction models of smoking are primarily medical models. This is evidenced in the language they use to describe smoking. The smoker is characterised as the 'addict', cigarettes are 'drug-delivery systems', and smoking is an 'illness' to be treated, either by psychological intervention or with pharmaceutical products such as NRT and Zyban. The intention in highlighting this is not to deny the bodily processes involved in smoking. However, it is contended here that the primacy of this medically derived bio-behavioural model has led attention away from complementary or alternative definitions of smoking (for example, smoking as pleasure, stress-relief or coping).

The conceptualisation of smoking in biomedical addiction models is also highly individualistic. Addiction is conceived as a personal battle between the individual's desire for the substance against their will to resist. Genetic explanations, which focus on the individual's individual susceptibility to nicotine, give further credence to this individualistic account. However, this theorisation fails to address the psycho-social dimensions of smoking, particularly the influence of social context on psychological processes. On occasion, reference is made to the influence of factors such as an individual's friends and family 'modelling' the addictive behaviour (Ogden, 1997). However, these constitute 'micro-social' factors, in that they refer to the immediate environment (the person's specific friends and parents) of that individual. There is no attention paid to 'macro-social' factors, such as the psychological meaning systems on which these friends, peers or parents draw to support their interpretation of smoking as a

normal part of life or as a socially unacceptable habit (Joffe, 1996). Furthermore, there is little attention to the ideological aspect of the environment. Macro-social factors (such as social meanings) are infused with ideology as they emerge from dominant institutions such as the mass media and scientists (Joffe, 1996). They hold considerable influence over what is said and believed about smoking and smokers for lay people. Although some reference is made within addiction models to the struggle an individual has with their smoking 'environment', this is considerably under-theorised compared with the theorisation of the struggle of the individual with his or her own psyche.

The under-theorisation of psycho-social factors in the face of smoking addiction models is pervasive in health psychology. Taylor's 'Health Psychology' textbook, for example, offers a basic summary of smoking research (Taylor, 1995). In the section on adolescent smoking, a highly complex model of why young people start smoking is outlined, involving no less than fifteen variables, including socio-cultural influences, social support, perceived smoking norms, modelling of smoking, personal goals and needs, psycho-social well being as well as biological influences (Taylor, 1995, p.193). Yet in her section on adult smoking, she simply details current addiction models such as that of Pomerleau & Pomerleau (1985; 1989) which theorise only two variables (biological properties of nicotine and psychological conditioning) as explanations of smoking. The implication is that adult smoking is far less complex than adolescent smoking, and can simply be accounted for as 'addiction to nicotine'. It is also implied that the numerous areas that constitute the psycho-social aspects of smoking are only appropriate for the study of adolescents and are not relevant for the study of adult smoking. These are the assumptions that are challenged in this thesis.

2.2.6 *Qualitative research into lay understandings of addiction and habit*

The previous sections have outlined and critiqued the dominant medical addiction model that is fundamental to much current psychological smoking research, including that concerned with the social class patterning of smoking. It is also important to note, however, that the concept of 'addiction' and the discourses surrounding it are drawn on by lay people to 'make sense' of their health behaviour (Berridge, 1999; Radley, 1996). In line with current thinking on the reflexive relationship between scientific knowledge and lay spheres (e.g. Irvin & Wynne, 1996), it is argued that these understandings of addiction may reflect the medical addiction model, but also perpetuate, change and resist it. This section considers the qualitative literature which has aimed to unpack some of the understandings of 'addiction', 'habit' and 'dependence' amongst a variety of lay populations.

Concepts of addiction can be argued to have important social and personal meanings for lay people. Conceptualising oneself as 'addicted to smoking' functions psychologically as a form of social explanation (I smoke because I am addicted). It is also a source of identity (I am an addict). Early research in the 1970's and 80's investigated the psychological consequences of considering oneself addicted. The primary finding was that addictive attributions are associated with the belief that quitting is difficult (Eiser, Sutton & Wober, 1978a; 1978b; Eiser, 1985). Smokers who characterised themselves as 'hooked' (addicted), rather than 'sick' saw themselves as extremely addicted, saw less benefit to stopping, and had less intention to try and stop. There were also group differences. Smokers who were female and older were more likely to ascribe to the 'hooked' (addicted) interpretation than others. Eiser, Sutton & Wober (1978b) also found that smokers were more likely to endorse an addiction model of smoking than non-smokers. The research of Eiser and colleagues into lay people's understanding of

smoking addiction was conducted before the more recent neuro-biological models of smoking emerged. It is interesting to consider, therefore, how these representations of addiction might have changed in the intervening time period, which, as the preceding sections have shown, has seen a strong drive on the part of medical and health professionals to have smoking classified as a serious drug addiction (RCP, 2000).

Some research has considered the understandings of addiction, dependence and habit in young people. Johnson et al., (2003) make the point that youths may have a different pattern of smoking than adults which may not be captured by traditional adult nicotine dependence measures such as the Faagerstom Tolerance Questionnaire (FTQ). For example, they may not smoke early in the morning, or every day, yet may be developing 'dependent' smoking patterns. They used a mixed methodology approach of analysing interviews and a card sort to understand 'tobacco dependence' with a sample of Canadian adolescents aged 14-18 year olds. They identified five 'domains' of dependence. The first of these, 'social dependence', represented a need to 'fit in', connect and 'party' rather than nicotine dependence; these smokers were therefore unlikely to smoke when alone. The second aspect was 'pleasure'; these young smokers were perceived to enjoy smoking as a treat or reward, and to enhance other activities. The third was smoking for 'empowerment'; to gain a sense of identity and independence, especially for those with a lack of control in their lives. The fourth was the 'emotional' aspect of dependence, which conceptualised smoking as a need to relieve or protect someone from emotional stress or unwanted feelings. The final aspect of dependence was 'full-fledged', where the young smoker is understood to 'need' cigarettes to 'feel normal' in terms of physiological and psychological dimensions. In these situations, the body is understood to 'be asking' for nicotine. They conclude that adolescents' experiences of tobacco dependence, which appears to encompass so much more than nicotine addiction, may be qualitatively different than that of adults.

This is an interesting paper which reminds one that dependence need not be conceptualised according to a narrow medicalized model. However, although there may be differences between adolescent and adult notions of dependence, these should not be exaggerated. Research by Laurier, McKie and Goodwin (1999) on the daily smoking of adult smokers found that many of the meanings identified here, such as pleasure, social connectedness, habitual, emotional and addiction were found in the cigarettes smoked throughout the day. What is more likely is that although some of the seeds of these conceptualisations go back to adolescent smoking, they also change over time in response to the longevity of the smokers' career, and the life-circumstances in which the smoker finds themselves.

Another qualitative study of young Canadian smokers (14-17) by O'Loughlin et al. (2002) supports the notion that there is much commonality, but also some differences in the conceptualisation of dependence of adolescents and adults. They evaluated the young participants' conceptualisations against more traditional scale measures of dependence such as the Hooked on Nicotine Checklist (HONC). They found that the idea of 'nicotine dependence' was indeed one with which their teenage sample could identify, summed up in the term 'need to smoke'. Interestingly, this 'need' was often described in physiological terms, as a feeling of hunger or emptiness, as well as in psychological terms ('your brain needs it'). However, the symptom of 'depression' as a withdrawal symptom had little resonance for them. Again, this suggests that although there are distinctive characteristics of dependence for adolescents, many of the concepts they hold may be similar to that of adults. It also suggests that the notion of 'need' may emerge early for some teenage smokers. This may particularly be the case for more disadvantaged young people. Wiltshire et al., (2005) found that for teenagers leaving school into unemployment, their smoking was already characterised as a response to despondency and boredom and was becoming embedded as part of their daily lives.

Another perspective on teenagers' understandings of cigarette addiction is provided by Moffat & Johnson (2001) who conducted a narrative analysis of the stories of girls aged 14-17 (n=12). They identified three major narratives; 'invincibility' in which the girls emphasised their control, 'giving in' in which they yielded to external forces (friends, peers, 'everybody') and 'unanticipated addiction'. In the invincibility narrative, girls identify themselves as the ones in control by their 'social' smoking, often not buying their own cigarettes. They distance themselves from the cigarette addiction of 'others', depicting them as ignorant, having psychological problems or being 'sad'. As Moffat and Johnson say, this is a paradoxical and resistant identity for the storyteller as they smoke, but do not identify themselves as a smoker. In the 'giving in' narrative, the storyteller is passive in the face of circumstance, such as exposure to cigarettes from friends or family; it is something that just 'happens'. There is thus the suggestion of inevitability and lack of control. The 'unanticipated addiction' story is one of surprise at being addicted, usually at a 'turning-point' in the story. The trigger for this realisation is not being able to stop, or physiological withdrawal when not smoking. Again, in line with the research by Johnson et al., (2001) and O'Loughlin et al., (2002), the phrases such as 'really really need' are used to express the sense of dependence they feel.

Other qualitative research with adult smokers supports the notion that 'control' is an important dimension in smoking narratives (e.g. Gillies & Willig, 1997; Louka et al., 2006). For example, Louka et al. (2006) found that perceptions of control was a key distinguishing item between those smokers who held a 'smoking works for me' discourse compared with those who held a 'struggle to quit' discourse. Those who subscribed to the former perceived themselves to have high control, both over their daily smoking which was assessed in comparison to others ('I don't smoke as much as X') and their perceived quitting in the future. Crandall & Moriarty (1998) and Crawford (1994) have also suggested that loss of control is a key marker of stigmatised health

threats. There might therefore be considerable identity benefits for non-smokers from identifying smokers as 'out of control'. This is one reason why the understandings of dependence, addiction and control of both smokers and non-smokers are considered comparatively in this thesis.

Most of the adolescents in the Moffat and Johnson paper drew on at least two narratives to illustrate their smoking, not just one. They fluctuated between being invincible at one time point, yet giving in at another. These narratives function both to protect the storyteller from blame (e.g. as the innocent victim of external forces or who unwittingly did not choose to be addicted) and to account for ongoing smoking (force of habit, fear of withdrawal). As will be shown in the discussion of the work of Laurier et al., (1999) and McKie et al., (2002) below, seemingly inconsistent story-telling around addiction and dependence is also common amongst adults who might choose to portray themselves as addicted/not addicted to smoking depending on their rhetorical purpose.

The findings of Moffat & Johnson (2001) and Johnson et al., (2003) that adolescents perceive there to be a range of experiences of dependency is explored further by a recent paper by Amos and colleagues with Scottish 16-19 year olds (Amos, Wiltshire, Haw and McNeill, 2006). Analysing paired interviews, they found three distinct groups in terms of how addiction was understood; those who thought they were not addicted (one-fifth), a majority who were ambivalent about their addicted status and those who thought they definitely were addicted (one-fifth). Those who thought they were not-addicted tended not to smoke daily, did not always 'buy their own' and contrasted themselves with more addicted smokers who experienced cravings and desperation. Ambivalent smokers, who formed the majority, both acknowledged their need for some cigarettes, but often highlighted their control or the social nature of their smoking. Finally, those who considered they were addicted were emphatic about their 'need' for

cigarettes, their inability to quit and the experience of withdrawal symptoms. Their smoking also extended beyond social or friendship contexts into daily life.

Amos and colleagues conclude that teenagers conceptualise a continuum of addiction with the social smoker who is 'in control' at one end and the habitual smoker who is 'addicted' at the other. The tendency to describe oneself in psychosocial terms as a 'social' smoker who is driven by the need for peer affirmation and bonding rather than nicotine addiction has also been found by Johnson et al., (2003) and O'Loughlin et al., (2002). This leads Amos et al., to conclude that smokers in late adolescence may underestimate the impact of nicotine on their smoking, preferring to emphasise its functionality in social terms. This leads us to consider how these designations of 'social', 'uncertain' and 'addicted' might change as the smoker moves into adulthood and into perhaps more established patterns of smoking behaviour.

Indeed, there is some research which has aimed to uncover the understandings of addiction and habit for disadvantaged smokers. Bancroft, Wiltshire, Parry and Amos (2003) considered explanations of the terms 'addiction' and 'habit' using a 'life-grid' approach with a disadvantaged sample from Edinburgh who lived in a poor area, with few local amenities. 100 interviews were conducted in total, with 50 females and 50 males from 25-40 years of age. They found that participants did not use the terms 'habit' and 'addiction' inter-changeably, but rather they assumed different meanings at different times of the day in different contexts. For example, the first cigarette of the day was conceptualised as 'addictive' due to the drop in nicotine levels. It was therefore a 'need' more than anything else. At work, or in situations in which people couldn't smoke, people described 'anticipatory craving' for nicotine and often coped with this by 'tanking up' (smoking a lot) before going into the situation of abstinence. For women caring for children, children represented a self-imposed restriction in some sense, in that

they felt they had to move rooms or were inhibited from smoking by their presence. However, this changed in the evening, when that 'wanted' one over a meal or night-time smoking was once again allowable, particularly given the lack of activities and boredom. They suggested that the sense of dependence on cigarettes is embedded in the routine of everyday life for disadvantaged smokers and is explicable in these contexts.

Studies with a varied socio-economic sample have also found that smokers utilise both addictive and habitual explanations throughout the day. Laurier, McKie and Goodwin (1999) considered the daily experience of smoking as 'embodied ritual'. Their sample was derived from varied socio-economic backgrounds including what they term 'working-class', 'middle-class' and 'upper-class' smokers. Smokers reported that the first cigarette of the day was, without exception, one associated with a great deal of pleasure as it offered the 'nicotine' rush with which to start the day. After that, for working participants, their working day was punctuated by 'habitual' smoking which is often described as 'reaching out' for a cigarette, suggesting the automotive nature of the behaviour. Other cigarettes represent *smoking for* time out, or for creativity in solving work problems. Smoking also patterns the return from work, the 'cigarette after a meal' and the last one before bed which offers a point of reflection on the day (Laurier et al., 1999). Thus they argued that smoking has multiple functions for most people, providing social bonding, filling time/boredom or as a response to emotional situations amongst others.

Furthermore, they found participants drew on accounts of active and passive addiction and habit in ways which did not always seem consistent. They argue that this is because people don't have a fully-formed, internally consistent health belief model which they map onto practices. This is supported by another study with a varied socio-economic sample (McKie et al., 2002) which found that smokers switched between the terms

‘habit’ and ‘addiction’ in the same account according to the rhetorical responsive purposes. For example, those currently smoking drew on the notion of ‘addiction’ to explain the ongoing effects of smoking and the difficulty of quitting.

There are several points to make here. Firstly, the idea that health beliefs are not necessarily ‘consistent’ and that the use of terms such as ‘addiction’ and ‘habit’ are rhetorically used, is well made. Billig (1987) argues that our ‘internal deliberation’ is often seemingly inconsistent, as we take sides with different arguments and perspectives much as a rhetorical scholar might do, depending on our intention. Secondly, in some sense it is not surprising that Laurier (1999) and McKie et al., (2002) found few SES differences in the functional use of cigarettes. These processes tend to exist, to some extent, irrespective of the social context and environment. Most individuals tend to experience boredom, social opportunities and emotions within their life contexts. It may be, however, that there are SES differences in a) the quantity of these experiences (e.g. people in lower SES contexts may experience more stress, have more coping responsibilities or more emotionally difficult circumstances, as suggested by Graham, 1993 a and b and Bancroft, 2003) and b) nuances in their expression which are related to the material circumstances and symbolic beliefs/values of that social group. For example, Chamberlain & O’Neill (1998), in a qualitative study of health beliefs of lower and higher SES smokers, have found that lower SES smokers exhibit a fatalism and powerlessness about their smoking in comparison with their higher SES sample. This might mean that addiction discourses resonate more in groups who already perceive themselves as powerless and are relatively fatalistic about the future, something this thesis aims to explore.

Finally, it is important to remember that discourses concerning dependence, control and addiction are culturally situated. Louka, Maguire and Evans (2006) have explored how

the presence of addiction discourses in the representations of Greek and UK smokers might reflect the cultural climate of their production, as part of a wider investigation into the social disapproval of smoking in these two countries. They found that addiction discourses tended to feature more heavily in the representations of smoking of UK rather than Greek smokers, particularly those who subscribed to a 'struggle to quit' rather than a 'smoking works for me right now' discursive repertoire. Participants who were engaged in the 'struggle to quit' drew on discourses of control, showing that their lack of control in terms of physiological and psychological addiction accounted for their difficulty in quitting. They also perceived quitting would be very difficult, in line with the previous research conducted by Eiser and colleagues (Eiser et al., 1978a, 1978b, Eiser, 1985). They argue that this may well reflect differential exposure to cultural narrative concerning smoking in the UK and Greece. They argue that in the UK, smoking is understood and presented as highly problematic. Furthermore, UK smokers are exposed to more tobacco control campaigns which are usually informed by addiction discourses.

This thesis therefore aims to draw out potential differences, in terms of the language, discourses and symbolic beliefs, used by UK participants from different SES groups concerning dependence and addiction as one of a range of psychological interpretations lay people offer of their smoking. These will initially be studied within an interview format. The findings will then be reflected in the statements used within the Q-methodology study to be sorted by higher and lower SES smokers to understand how discourses of dependence and addiction are related holistically to other aspects of smoking identities. The theorisation of social identity, including addictive identities, is considered further in Chapter Three.

2.2.7 Conclusion and summary for addiction models

In conclusion, there is no doubt that nicotine is a highly addictive substance. Indeed, the intention in this thesis to focus on the social meaning of being a smoker in different class groups in no way hinges on discounting or disproving the addictive qualities of nicotine. Rather, the intention is to open up the conceptual space by questioning the assumption that bio-medical ‘addiction’ is the sole feature of adult smoking about which psychologists should be concerned. Health psychologists have much more readily accepted the powerful influence of psycho-social factors (such as context, identity, and norms) on the psychology of drinking and alcohol abuse than on smoking. This may be due to the fact that the dependency aspect of alcohol has been long accepted by scientists as well as lay people. The labelling of smoking as a serious medical addiction has been much more recent and controversial. Perhaps in the attempt to clearly bring smoking into the ‘biomedical addiction’ fold, other psychological definitions and discourses about smoking have been sidelined. A narrow biomedical model is found to be particularly lacking in the face of social class differences in smoking behaviour.

2.3 Knowledge, attitude and belief models of smoking

*‘Smoking is still, in a particular sense, under volitional control
and is the product of a type of decision-making’*

(Eiser, 1983, pp. 54)

2.3.1 Introduction to the KABP paradigm of rational-decision making

Another key strand of research into smoking, deriving primarily from social and health psychology, exists within the Knowledge-Attitudes-Beliefs-Practices paradigm (KABP). The KABP sees all health behaviours, including smoking as the outcome of a rational decision-making process (Joffe, 1996). There is considerable implicit tension, therefore, between current addiction theories that characterise the smoker as ‘out of control’ and the KABP literature, which characterises the smoker as a rational

individual, weighing up their knowledge, attitudes and beliefs about health, risk and smoking before deciding to smoke. In this section, the primary features of the KABP paradigm are outlined, before considering empirical research based within this paradigm in relation to smoking class differences. It will be argued that although the KABP paradigm does make reference to 'subjective norms', this aspect is under-theorised. There is also an over-emphasis on perceived vulnerability to health risks. This is problematic given that evidence suggests that high knowledge of the health risks of smoking is prevalent across all class groups.

2.3.2 Outlining the Knowledge-Attitude-Belief-Practices models of smoking

The essence of the KABP paradigm is that latent constructs' such as a person's beliefs, attitudes, sense of personal control and risk estimates in relation to the health behaviour predicts whether or not the person will carry out the behaviour. Consequently, it is hypothesized that behaviour change may be possible if cognitions about smoking are modified. There are at least three multi-dimensional health models which theorize this relationship between cognitions and behaviour: the Theory of Planned Behaviour and Reasoned Action (TBP/TRA) (Ajzen, 1985) and the Health Belief Model (Rosenstock, 1966; Becker, 1984).

The Health Belief Model (HBM) states that whether or a person practices a particular behaviour (smoking) can be predicted from two factors. The first factor is perceived vulnerability to a health threat, comprising three aspects: perceived vulnerability to specific threat ('I am vulnerable to lung cancer'), the perceived severity of threat ('lung cancer is a serious illness') and general beliefs about health ('my health is important to me'). The second factor is the belief that a specific health behaviour (stopping smoking) will reduce the threat, in terms of its efficacy ('stopping smoking will prevent lung cancer') and the belief that the costs ('stopping smoking means withdrawal symptoms')

outweigh the benefits ('it is worth quitting to prevent lung cancer even though it will be hard').

Perceived vulnerability has received much attention as a factor predicting behaviours and behaviour change. The 'optimistic bias' states that people often perceive themselves as less likely than the average person to be at risk of a specific threat (Weinstein, 1982; 1987). It has been argued that positivity biases may jeopardise health status as they encourage unrealistic optimism and thus disregard for health risks (Weinstein, 1982; 1987). There is considerable debate over whether smokers assess their risks accurately. A review suggests that the accuracy of smokers' numerical risk assessments depends on which health outcome is rated. Smokers' tend to over-estimate overall lung cancer risk, but under-estimate all deaths from smoking (Weinstein, 2001). Smokers acknowledge that smoking increases health risk, but judge the increases to be smaller in comparison with non-smokers. They also minimise the personal relevance of the risk to themselves, believing themselves to be less vulnerable personally to health risks such as lung cancer than other smokers (Weinstein, 2001).

Some research has investigated the cost-benefit aspect of the HBM with regard to smoking. Sutton (1989) has studied the personal beliefs about quitting amongst 1305 adult smokers. Subjects were asked to rate the outcomes of continuing or stopping smoking in terms of how much they feared or wanted these outcomes. Strong intentions to stop were associated with rating every positive outcome as more desirable and every negative outcome as less desirable. Path analysis showed that perceived benefits influenced intention to stop, which in turn influenced trying to stop six months later. However, little research has been published using the HBM to predict smoking, in contrast to its extensive use for the investigation of other health behaviours.

The Theory of Reasoned Action (TRA) states that health behaviour is a direct result of behavioural intention. Behavioural intention itself is the result of two components. The first is 'attitudes towards the action' (smoking), in particular beliefs about the outcome ('bad for health') and evaluation of these outcomes ('being healthy is desirable'). The second is 'subjective norms' regarding the action, which comprise normative beliefs ('significant others think I should smoke') and motivation to comply ('I care what they think'). The Theory of Reasoned Action was built upon to produce a new model, the Theory of Planned Behaviour (TPB). The major change is the introduction of an additional factor, 'perceived behavioural control'. This refers to the extent to which the person feels they behaviour is under their own volition ('I could stop smoking if I wanted to'). These factors lead to intention to fulfil the behaviour, then performing the health behaviour.

There is evidence that some components of the model provide limited predictability for smoking. Norman, Conner and Bell (1999) tested the model as a predictor of smoking cessation and found that perceived susceptibility and control did predict intention to quit. However, a rather major drawback of the TPB is that it often predicts *intention* to smoke/quit smoking which in turn does not predict the act of quitting (Sutton, 1989).

2.3.3 *How the KABP model accounts for class differences in smoking*

Several large-scale surveys have investigated the differences in knowledge, attitudes and beliefs about smoking in different classes. Looking firstly at the health knowledge of smokers, there is mixed evidence that health-related knowledge about smoking varies by SES. One wide-scale study in the US questioned individuals about their knowledge of the relationship between cigarette smoking and specific diseases such as lung cancer, emphysema and heart disease (Brownson, Jackson-Thompson, Wilkerson & James, 1992). Knowledge of smoking as a cause of these diseases was generally lower amongst

older, female, less educated smokers. However, these findings must be set against the fact that knowledge levels of the risks of smoking were generally very high across all class groups. In the UK, a recent reanalysis of the Health and Lifestyles Survey (1996-1997) (HEA, 1998) shows that knowledge of the dangers of smoking to health and of passive smoking show little variation across occupational group.

Indeed, the lack of class differences in surveys of knowledge, attitudes and beliefs about smoking is striking. Goldstein (1993), for example, found few class differences in a survey of smoking attitudes and behaviours in Canada. His argument, which is perhaps plausible in the English context, is that smoking prevention campaigns have fostered a general climate of high knowledge about the risks and antagonism towards smoking across all social groups. In other words 'everyone knows' smoking is bad for you. An additional explanation may be that such a social climate creates demand characteristics in smoking surveys. Smoking surveys, with limited response options, may offer individuals the opportunity to record the received wisdom that smoking is risky and bad for your health, but leave little room for them to show more complex and perhaps contradictory attitudes and emotions towards this knowledge.

Another aspect of the Theory of Planned Behaviour that has been examined in relation to class differences is perceived control (or self-efficacy) over health. Working class people may have a more fatalistic attitude towards their health and the causes of disease in general (Calnan, 1989). A large-scale survey (n=4221) has shown that fatalistic beliefs are much more likely amongst low SES groups, and amongst smokers in particular (Vetter, Lewis and Charny (1991). It is suggested that low SES smokers start and continue to smoke as they have a fatalistic attitude towards health. Calnan (1989) argues that the relationship between Health Locus of Control and smoking is never more than modest even within different SES contexts. However, this may be due to the

limits of this particular conceptualisation of control. Qualitative research outside the KABP paradigm has indicated that lower SES individuals have a lower perception of control over their health in general, and smoking-related health in particular (Chamberlain & O'Neill, 1998).

Looking at the evidence concerning subjective norms of smoking, Jarvis and Wardle (1999) have shown that household or parental smoking are key predictors of smoking behaviour. This relationship holds independently of social class, for example, parental influence is not stronger in any particular class group. However, class, parental smoking and household factors are associated in a different sense. As the evidence in Chapter One showed, higher numbers of lower income parents smoke and higher numbers of low income households are smoking households. It seems highly plausible, therefore, that social norms of smoking exist in low income families and social milieu with high levels of smoking. Research with adolescents shows that subjective norms (what significant others think) differ between SES groups. A study by de Vries, for example, shows that higher SES adolescents experience less positive norms and less social pressure to smoke than lower SES adolescents. It is concluded that smoking amongst lower SES groups is embedded in the social culture (de Vries, 1995). However, little research from within the KABP has elucidated the exact nature or influence of these smoking norms in adults.

2.3.4 A critique of the KABP paradigm as an account of class differences in smoking

The KABP approach has been critiqued for offering a primarily individualist account of health behaviour and ignoring social context (e.g. Campbell, 2000; Joffe, 1996; Radley, 1994). Many of the generic criticisms that have been made are particularly pertinent with respect to the smoking literature on class.

Firstly, as with addiction models, the KABP paradigm can be argued to offer a primarily individualistic conceptualisation of smoking behaviour. The smoker is seen as an individual decision-maker who determines his or her behavioural intentions alone. The Theory of Reasoned Action does include a component labelled ‘subjective norms’ which refers to the smoker’s perceptions of the attitudes of significant others. However, this is arguably the least theorised part of the model. It is clear in the review of literature based on the KABP paradigm above, for example, that little research has investigated or clarified this particular psycho-social factor. This is despite the fact that, as the research in Chapter One indicated, highly disparate norms of smoking exists between the classes.

Secondly, as with addiction models, the concept of ‘social’ offered in the KABP paradigm is highly individualistic. The concept of the social norm here only pertains to the ‘micro-social’, referring to the immediate environment in terms of family, parents and friends known as ‘significant others’. There is no reference in the KABP paradigm to these ‘macro-social’ understandings of behaviour, such as cultural assumptions, meaning-systems and social identities that are drawn on to make sense of health behaviour (Joffe, 1996). These would play a major role in the macro-social realm (Joffe, 1996).

In the case of class differences in smoking it is particularly important to look beyond an individual’s immediate ‘micro’ social influences, such as their particular parents or their particular friends. A person in a disadvantaged group is much more likely to have significant others such as parents who smoke (Ferri, 1993). However, it is a mistake to therefore conclude that simply being in that specific household leads that particular individual to smoke. Parents and households exist in a social context in which smoking or not smoking is normative and sustained by the shared beliefs of that social group. Disadvantaged parents and their households exist in an environment in which heavy

smoking is normative, just as more advantaged parents live in households in which smoking is not. The challenge, therefore, in this thesis is to tap the common psychological meaning systems and identities concerning smoking, which individuals who live in the same environment use to make sense of their smoking.

The influence of social context on psychological processes has been considerably under-estimated in the KABP literature. There is, on occasion, an acknowledgement of different social contexts. For example, Jarvis and Wardle (1999) note that in developing countries such as China (where 70% of all men smoke) smoking, and consequently smokers, are associated with Western prosperity. This contrasts with Western countries such as the UK, US and Canada where a more dominant anti-smoking culture now prevails. However, little research has investigated which social meanings or identities emerge concerning smokers in these different cultural contexts, nor how they differ. The effect of such different social meanings and identities on the psychology of smokers who live in these contexts has also been left unexplored.

The cost-benefit rationality of the KABP paradigm has also been criticised (Joffe, 1996). In this paradigm, the smoker is theorised to be a rational decision-maker, weighing up their risks of smoking against perceived benefits. This is problematic for two reasons. Firstly, it neglects the affective dimensions of smoking. People have strong feelings about smoking, both whilst enacting the behaviour and thinking about it in a more abstract sense. Experimenting with smoking in adolescence, for example, is a time of heightened emotion, eliciting feelings of fear, excitement and pride. Similarly, evidence shows that thinking about stopping smoking may produce feelings of fear, worry and not being able to cope (Russell, 1974).

Secondly, perceived vulnerability to risk has proven to be a poor predictor of actual behaviour. This has been pointed out by critics of the paradigm (e.g. Joffe, 1996). It has

also been acknowledged by those working within it (e.g. van der Plight, 1998). Indeed, the 'urge' to smoke is often said to be 'irrational' in the face of knowledge about the health risks. As a consequence, health psychology has found smoking a particularly difficult behaviour to theorise from within the KABP paradigm, as it, perhaps more than diet and exercise, appears not to be a product of rational-decision making. The conspicuous lack of success of smoking interventions which have aimed to stop smoking though attitude change has led many to conclude that change is difficult, if not impossible (van der Plight, 1998). The problem may be that the KABP paradigm has emphasised and theorised assessment of health risks at the expense of all other variables. Clearly, awareness of risk has some importance. If one does not know one is at risk then one is unlikely to change one's risky behaviour. However, it is not the only, or even primary, determinant of health-behaviour.

2.3.5 Tones Health Action Model

This section reviews the Health Action Model or HAM (Tones, 1987; Tones & Green, 2004) which is a theoretical attempt from within health promotion to go beyond the KABP paradigm to explain the determinants of health actions. The multi-factorial model HAM is shown in Figure 2.1 (taken from Tones & Green, 2004, Chapter Three, p.79). There are two major sections. The first is made up of the normative system, belief system, motivation system and the self/personality which translates into the 'behavioural intention' to perform a health behaviour. The second, consisting of knowledge, skills and environment (physical, socio-economic and socio-cultural) are the factors which lead to the behavioural intention being translated or not translated into health action. If it is translated into health action, it then has the potential to enter a person's routine, which can lead to confirmation of its benefits. If the innovation (adopting the health behaviour) is rejected, the person may relapse, and thus the

intention to perform the behaviour is reviewed. I will consider each of the parts of the model in detail, then consider its advantages and disadvantages as a model of health action.

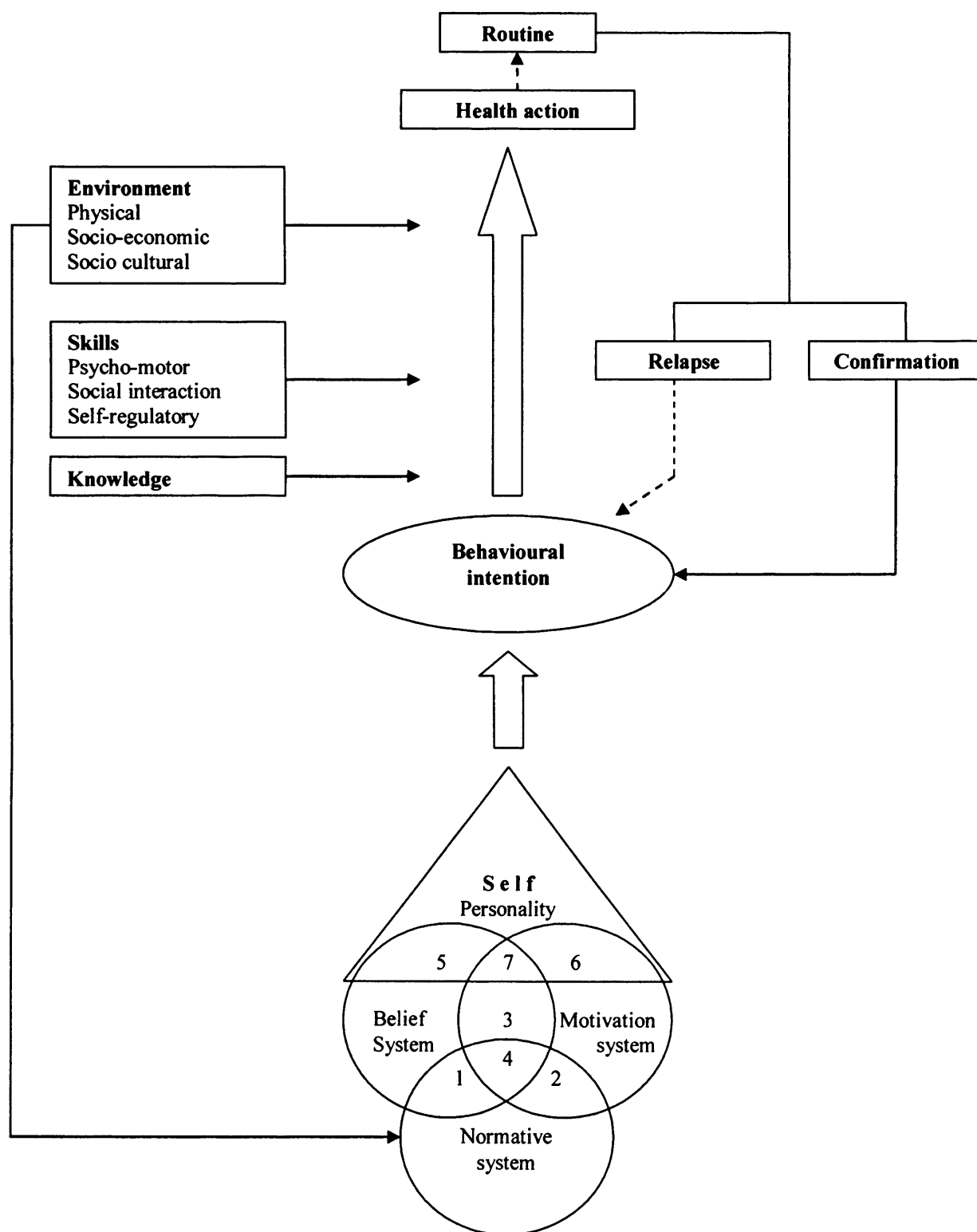


Figure 2.1 The determinants of health action (Tones' Health Action Model)

The first set of constructs all feed into the individual's intention to perform the behaviour. As Tones says, the 'belief' or 'cognitive' part of this model owes much to the Theory of Reasoned Action (Fishbein & Ajzen, 1975; also Becker, 1984). Giving the example of beliefs about smoking, he says 'it is obvious that a kind of mental balance sheet is operation and that the outcome will depend on the ultimate balance and relative strengths of the beliefs about the positive and negative outcomes of giving up smoking' (p.83). However, belief does not always translate into action, because of other 'motivational' forces which are affective rather than cognitive. These include 'values' (such as moral values or valuing self-competence), 'attitudes' towards the behaviour, 'drives' and 'emotional states'. In the situation of quitting smoking, he gives the example of numerous types of values which might be taken into account, such as aesthetic values, expense values, social values (social acceptance), work (threat to promotion) and family values (nurturing children) which might be related to smoking. People do not always comply with their inner values, however, as they are also affected by 'drives' (innate or instinctive goals concerning lower-order needs) and 'emotional states' such as anxiety or cognitive dissonance. Another driver of behavioural intention the 'normative system' which is conceptualised as 'a network of social pressures which might be brought to bear on an individual's intention to adopt or reject health actions' (p.85). He argues that proximal ones such as one's immediate family and friends ('significant others') have more of an impact than more distal ones, such as community pressure, or mass media norms which have the least impact, although as he points out, due to the effects of socialization, one's immediate family are likely to enforce community norms. Stigma is seen a particularly important effect of social pressure on individual behaviour. These factors are inter-actional, as represented by the 'segments (numbered 1-7) in the diagram.

The final aspect of individual intentions is the self-concept, in which the notion of self-empowerment is central. He offers a 'taxonomy' of the self incorporating eight dimensions centred on three constructs; 'academic', 'social' and 'self-presentation' (including body image). Two particular aspects of the self are important. One is the affective part of the self-concept; self-esteem. This can affect health behaviours in multiple ways; directly such as in mental health and less obviously, those with low self-esteem may be more likely to conform to interpersonal pressures, or reduce cognitive dissonance. Control beliefs are important to self-esteem, for example, when people are out of control they may lapse into learned helplessness, although it depends on the attributions of causality that they make (Seligman, 1975). Although there are various levels of control (Sarafino, 1990), the best known is the locus of control which is understood to refer to the subjective sense of control felt by individuals which can be internal (and thus more powerful) and external (and thus controlled by chance/luck or by 'powerful others'). This is also related to the second important aspect of self, self-efficacy or the sense in which one is able to achieve a particular outcome (Bandura, 1986). The extent to which one feels one has self-efficacy is dependent on past experience of mastery, their physiological state, verbal persuasion and observing others (Bandura, 1986). Tones also considers personality as one of the factors contributing to behavioural intention, which refers to the relatively fixed enduring attributes of the individual, such as coherence, hardiness and resilience, as well as 'sensation-seeking' and radicalism/conservatism. Together, this 'self-concept' mediates the belief, motivational and normative system to create 'behavioural intention'.

The final part of the model relates to how the individual's behavioural intention translates into practice. In other words, one produces, in this model, 'empowered intentions' from the self-concept, however, whether they are carried out or not is affected by the facilitating or inhibiting effects of the physical, social and economic

environments. The task of health promotion is to remove these barriers and empower communities as well as giving individuals a chance to achieve their goals. The first of these is 'knowledge' which does not refer to the knowledge inherent in the individual's beliefs which may have already influenced intention, but rather knowledge given to people who have already decided to act (e.g. how to access services). The second of these is 'skills' such as cognitive skills (e.g. literacy, decision-making), life skills (e.g. social interaction) and assertiveness as well as self-regulatory skills, such as self-reinforcement. The third of these is the role of the environment, which constitutes the physical environment (such as natural and man-made disasters), socio-economic environment (such as poverty and the effects of inequality) and thirdly, the socio-cultural environment (normative practices which are intrinsically unhealthy). Thus his call for empowerment covers not just individual empowerment to make good healthy choices, but social and environmental empowerment at a community level, for example, through things such as social capital so that environmental factors do not limit the possibilities of self-determination.

Having made a healthy choice, the individual has to then keep making the same healthy choice and avoid relapse by the behaviour becoming 'routine'. He draws on the Transtheoretical model (Prochaska & DiClemente, 1984; Prochaska et al., 1992) to show how it might related to the conceptual schema used in the HAM. The key feature of the TTM is that individuals move through a series of stages (pre-contemplation, contemplation, behaviour change, maintenance) but may relapse at any time, although they may then start again through the stages. Tones supports the idea of this type of stage model, particularly for the difficulty of developing a routine, which as Prochaska said, may take from six months to five years. He suggests that self-regulatory behaviour is key to this, for example, where competing motivations emerge (values vs drives). These involve self-monitoring (reflexive self-consciousness about behaviour), self-

evaluation (judging oneself against external standards) and self-reinforcement (positive and negative self-reward).

There are several good points about this model. Firstly, it attempts to show the complexity of health behaviours at both the individual and social/environmental levels. It was argued in the first section that much of the research which mainstream psychology has conducted into smoking has focused on a relatively individualised addiction model and neglected wide 'macro-social' factors which the HAM incorporates. Secondly, it also places at the centre both normative and motivational factors which have been arguably under-theorised within existing KAPB models and research. West (2005) makes the case that any model of smoking behaviour needs to consider '...motivational processes that are not necessarily accessible to conscious awareness...and how an individual's desires and values are shaped and changed' (p.1038). Thirdly, it places empowerment at the centre of health promotion. In a recent review of critical health psychology, for example, it was argued one of the key features of this type of health psychology should be to place power processes in the centre and to consider how health is promoted, maintained but also inhibited by power processes in both micro and macro spheres (Prilleltensky & Prilleltensky, 2003). They believe that the wider definition of health offered by WHO and embraced by Tones, of health as comprising 'positive physical and emotional features that enable individuals and groups to pursue their goals in a context of equality and justice' (Prilleltensky & Prilleltensky, 2003, p. 198) should be the basis for critical health psychology practice.

However, although it is difficult to argue with this overall message, the HAM itself as a (predictive?) model of health behaviour can be critiqued. As Tones himself says 'it draws eclectically, pragmatically (and unashamedly!) on a number of key models and theories' (p.78), most notably the Theory of Reasoned Action which is represented in

almost its entirety (Tones, 1987); the health locus of control and the theory of self-efficacy (Bandura, 1986), Weinstein (1982) and the Transtheoretical model (Prochaska & DiClemente, 1984). In blending these models, he leaves himself open to many of the criticisms which have been made about them individually. For example, this is essentially a social cognition model with environmental factors ‘out there’ on one side. Thus there is still a relatively individualistic understanding of beliefs, attitude and motivations rather than one which emphasises their socially shared creation and nature (e.g. Joffe, 1996). In citing Weinstein’s research into unrealistic optimism (1982), he also offers a relatively uncritical acceptance of the notion of ‘objective’ (i.e. statistical) and lay risks, which has been frequently been challenged as offering a false division between ‘irrational’ lay understandings and objective scientific knowledge (e.g. Joffe, 1999). He does acknowledge that some individuals seek risk and danger, for example, citing the notion of ‘edge-work’ (Lyng, 1990 in Tones & Green, p.91). However, it does not seem likely that disadvantaged smokers are engaging in ‘edge-work’, nor that they are unrealistically optimistic about the risks. Rather, as Graham’s work in the next section will illustrate, their smoking is connected with alternative, or concurrent notions of coping and pleasure which ‘make sense’ in their life contexts (e.g. Graham, 1993a). Finally, the notion of ‘behavioural intention’ (as in the Transtheoretical model) has also received much criticism as it has been shown to be a poor predictor of behaviour change (e.g. West, 2005).

Ultimately, the strength of this model is also its weakness. It aims to describe complex multi-factorial behaviours, such as ‘health behaviours’. However, by aiming to do justice to their complexity, it is not parsimonious (simple) which is a key criterion for health behaviour models. It seems pertinent to question why little applied research in health promotion appears to have used it as a theoretical model, unlike the somewhat derided HBM and TPB/TRA and it seems likely that its considerable complexity might

be the answer. It is difficult to describe and analyse each part of the model; there are eight 'macro' variables such as beliefs, motivation, environment etc, each of which is sub-divided further (so motivation is made up of values, attitudes, drives and emotions; self-concept is made up of eight other variables) plus seven points of interaction (the 'segments' numbered on the diagram) between these, before we consider the pathway of intention to behaviour to routine. Trying to incorporate over thirty or forty concepts and processes into a model of health behaviour may do justice to the complexity of the phenomenon, but it makes it almost impossible to operationalise in quantitative studies, or to see what it would add to qualitative research.

A final point to make concerns the continuing influence and prevalence of the KABP paradigm. It is certainly the case that some sections of health psychology have moved on from the KABP, particularly through critical health psychology. But equally, both social psychological and mainstream health psychology researchers still use this paradigm extensively. For example, in social psychology, many meta-reviews of the TPB and TRA have taken place, asking what, if any variables should be added but fundamentally supporting the model (e.g. Hagger & Chatzisarantis, 2005; Connor & Abraham, 2001; Kaiser & Gutscher, 2003; Johnston & White, 2004; Perugini & Bagozzi, 2001). Similar reviews have taken place concerning health behaviours (e.g. Hagger & Chatzisarantis and Biddle, 2002; Finlay, Trafimow & Villareal, 2002) as well as original research using the paradigm, specifically for smoking⁵ (e.g. Guo et al., *in press*; Smith, Bean, Mitchell et al., *in press*; Van Zundert, Engels & Van den Eijnden, 2006; Bledsoe, 2006). As such, I would argue that the influence of environmental and socio-cultural influences on psychological processes related to smoking do go underestimated in much mainstream health psychology literature.

⁵ I have only included a selection of research from 2006 to avoid a lengthy list

2.3.6 Conclusion and summary for the KABP paradigm

In conclusion, there is modest evidence that certain aspects of the KABP such as control might be linked to the social patterning of smoking. However there is very little evidence for the influence of other variables such as perceived risk. The empirical evidence challenges any assumption that it is lack of knowledge of the health risks in poorer groups which accounts for their greater tendency to smoke. The central focus in the KABP paradigm on 'health risk' has not proved as theoretically productive as might be hoped in the face of the 'poor smoker' phenomenon. More recent models of health behaviour in general (e.g. Tones & Green, 2004) and smoking in particular (e.g. West 2005; West & Sohal, 2006) have emphasised the motivational and affective antecedents of smoking (cessation) behaviour, as well as the role of environmental factors (Tones & Green, 2004). However, the continuing focus on social cognition models in much of mainstream social and health psychology has meant that the material and socio-cultural contexts of smoking, and the identities and meanings which are developed within them, have gone less explored in some parts of the literature. We now consider some of the qualitative research into smoking and class which has aimed to fill this gap.

2.4 Qualitative research into smoking and class: uncovering the 'smokers' world'

'The only pleasure I have is smoking'

(Mother under the age of 20)
(Graham, 1995, pp. 36)

2.4.1 Introduction to this section

This section considers some of the qualitative studies which have aimed to draw out the meanings and understandings of 'smokers' world' from the perspective of the smoker, particularly the disadvantaged smoker. Initially, I consider in detail one qualitative and one mixed methodology study by Graham (1987; 1993a) alongside more recent

epidemiological work (e.g. Graham, Inskip, Francis, Harman, 2006). This does not represent the total of her considerable body of work, but I have focused primarily on the seminal qualitative studies which first identified the notion of ‘coping’-in-poverty through smoking. I then consider further studies which have added to our understanding of the experiences of smokers in the context of material disadvantage and the possible policy implications (Bancroft, Wiltshire, Parry and Amos, 2003; Parry, Amos, Bancroft and Wiltshire, 2002; Wiltshire, Bancroft, Parry & Amos, 2003; Stead et al., 2001). I will consider qualitative research into class differences into health beliefs in the next chapter (3.3)

2.4.2 Qualitative research with disadvantaged smokers and communities

2.4.2.1 Graham’s work: ‘Coping-in-poverty’

In an early qualitative paper, Graham (1987) outlines the connection between smoking and motherhood and how it may be linked through poverty. She does point out that the link is not found in all ethnic groups, for example, in Afro-Caribbean groups and Asian groups, even though these mothers are more likely to be in the lowest socio-economic categories. To this extent, she defines maternal smoking in the UK as a white, working-class phenomenon. The interviews reported here took place with 57 female smokers and non-smokers on low income equivalent to benefits at this point in time, stratified from a larger sample to ensure that low income and one-parent house-holds were represented. Participants completed an interview, and the majority a 24 hour diary of their daily lives, plus a subjective health profile. The majority were full-time carers of small children, usually more than one, with only one in four having part-time or full-time work.

She found that smokers tended to score more highly on many dimensions of the health profile, such as having lower energy, being socially isolated, needing sleep and having

emotional reactions, than the non-smokers. She found that smoking was associated with taking breaks from caring for smokers. Women had two major tactics for when they felt they could not be 'calm' with their children; one was making a symbolic space between them, such as going into another room, or for the smokers, having a cigarette outside the kitchen. The other tactic was to do something for the self; such as have a cup of tea, and, for the smokers, to have a cigarette. Thus for those who smoked, the majority of them identified smoking as their main strategy for re-establishing their ability to cope with their children. It is not simply a way of structuring caring, but of re-structuring the day when the normal structure breaks down. Smokers in particular were vulnerable to breakdowns such as losing their temper and feeling on edge. Furthermore, for these women, many of whom were cutting down on their own food, smoking represented their 'only luxury' or leisure activity which they had for themselves within the context of caring-in-poverty; 'In a life-style stripped on new clothes, make-up, hair-dressing, travel by bus and evenings out, smoking can become an important symbol of one's participation in an adult, consumer society' (p.55). Thus Graham concludes that smoking had a paradoxical role in the lives of poor women 'like tranquilizers, alcohol and coffee...it works to promote women's sense of well-being, while threatening their physical health (p.55). It promotes family well-being on the one hand, but threatens the children's physical health.

As suggested in the introduction, Graham's work has been the subject of considerable debate. Jarvis and Wardle's (1999) key criticism of the work is that it wrongly interprets subjects' reports of the calming effects of smoking in the face of stress (Jarvis & Wardle, 1999). They argue that nicotine is a pharmacological stimulant, not a sedative. There is no evidence that it has a calming or relaxing effect over and above the relief of negative mood caused by negative withdrawal. The reports from smokers of the calming effects of smoking may simply refer to relief of nicotine withdrawal. Studies show that

ex-smokers and non-smokers report lower levels of perceived stress, consistent with the idea that smoking may be a stressor rather than relieve stress (Cohen & Lichenstein, in Jarvis & Wardle, 1999, Chapter 11, 5.5). However, this criticism misses the point. Whatever the physiological effect of nicotine given blind in a laboratory, smoking is experienced and described by low income mothers as 'calming' in the face of stress. This is the explanatory account they give of their experience of smoking which is psychologically meaningful for them.

However, although I don't question that low income women perceive cigarettes as a functional way of coping, one could question the conclusion that it actually does promote women's sense of well-being or helps them to cope in the context of poverty. The evidence shows that ex-smokers and non-smokers have lower stress-levels than smokers, not the other way around (West & Hajek, 1997; RCP, 2000). Indeed many of the symptoms which Graham identifies as related to the need to cope through smoking, such as having a bad temper, feeling agitated and not calm, irritability and feeling emotional, could be argued to be part of the normal pattern of hourly withdrawal of someone heavily addicted to nicotine (West et al., 2000). Furthermore, although smoking represents taking time out, it is also a 'need' for heavily addicted smokers. It also therefore represents a challenge in terms of managing time and another demand which cannot be ignored alongside the demand of caring for small children; perhaps the loss of temper many smokers report also occurs when these demands collide. In fact, one could, on the basis of this paper alone, read the evidence and supporting quotes in an opposite way; smoking may actually make parenting in poverty harder. The smokers in this sample report having more difficulty staying calm and being in control than the non-smokers. As such, it cannot be represented as promoting well-being in this context.

It also appears likely that depression may be a strong mediator in a deprived material context. All of the symptoms on the health profile on which the smokers scored highest, such as difficulty sleeping, emotional breakdown, loss of energy, are also symptoms of depression. It seems likely that the mothers who depend the most on smoking may be the mothers who are most depressed; this would also explain their rating of themselves as socially isolated. Smoking rates amongst clinically depressed individuals are high, which may be the result of the shared neural substrate pathways which are modified by smoking and depression (Quattrochio & Baird, 2000). It is argued to be particularly difficult for depressed people to quit smoking as it may mitigate their depressive symptoms, again, through their self-medicating use of nicotine (Quattrochio & Baird, 2000). Furthermore, quitting smoking can trigger a depressive episode in a clinically vulnerable individual (RCP, 2000). Indeed, Graham and Der (1999) have found that being in poor psychological health is the most powerful predictor of high rates of cigarette consumption, alongside SES, age and pregnancy status. Lone parents are particularly at risk of unhappiness and depression and are also likely to be smokers (Graham & Blackburn, 1998). The links between smoking and psychiatric morbidity are explored further in the next paper, although again, a question-mark remains to what extent being a smoker, and experiencing withdrawals, might make depressive symptoms more unstable as well as mitigating them.

In the seminal report 'Life's a drag', Graham (1993a) firstly outlines a short history of women smoking, followed by details of a study conducted with mothers in the catchment area of two large maternity hospitals in Nottingham and Coventry. They were interviewed when their babies were six months old. The sample was predominantly white (97%), in line with Graham's contention that 'class differences have widened, giving cigarette smoking an increasingly working class identity. As a result of these trends, white working class women have become an important sub-group

within the smoking population' (p.41). They were included in the sample if they, or their partner (if their occupation was unknown) engaged in a skilled manual (3M), 4 (semi-skilled manual) or 5 (unskilled manual) or a housewife/unemployed. 34% of the sample had no-one in full-time employment in their household, with about 33% on income support and another 11% receiving family credit (top up for low income working parents). The vast majority were young women under 30 who were caring for families as a full-time occupation, only 4% were in full-time employment. 23% were lone mothers. The sample was designed to ensure half were smokers, so 52% of the sample was smokers and 11% ex-smokers. The interview included fixed choice questions, similar to those in other large scale surveys, and open-ended questions where mothers were invited to highlight experiences and issues which were important to them. It is important to note that this was not a random sample, however, but one specially selected to represent this disadvantaged population of mothers.

As might be expected, there was a high level of knowledge about the health risks of smoking. However, as Graham points out, this is not necessarily translated into action; only 45% of the smokers reported stopping or cutting down when pregnant and smoking levels often returned on having the baby. The question this report set out to consider, therefore, is why smoking might be sustained in white working-class communities despite health knowledge, particularly for lone mothers. At a statistical level, the heavy smokers in the sample were likely to be caring for more children, and in more disadvantaged circumstances such as inadequate rented accommodation or unstable housing. They were also more likely to be caring for other relatives who needed help with everyday tasks. They also scored highest on a scale of disadvantage including not having a telephone, or a car, having no-one employed in the household, having debts, bringing up children alone, never been employed and living in Bed and Breakfast for more than a month. They often accounted for their smoking in pregnancy through the

stress that these things implied; smoking thus is seen to represent a 'coping' strategy to structure lives in times of high psycho-social stress and in circumstances of material poverty.

There was also, as would be expected with young mothers, significant levels of exhaustion and about 1/3 reported symptoms which would be consistent with psycho-social or psychiatric problems. Although this sounds high, this is consistent with other surveys of young women with dependent children caring full-time. Smokers were more likely (46%) compared with non-smokers (31%) to score highly on this. They were also more likely to report their health as fair or poor (20% of non-smokers vs 41% of heavy smokers). Interestingly, the group who scored the best on the psychiatric scale (GHQ12) were the ex-smokers (26%) suggesting that psychiatric health is improved by giving up smoking, or conversely, that those who felt emotionally well were more likely to try to give up. Smokers felt their neighbourhoods to be less safe and less integrated into them; however, I would argue that this negative view may be a result of having a globally depressed outlook as much as an assessment of the nature of the neighbourhood itself.

This was very much a seminal study which identified a group of lone mothers as a group of persistent heavy smokers living in disadvantage who perceive their smoking as their tool for coping with their considerable life and psycho-stress. There are several points which can be made. Firstly, as Graham points out as a caveat early on, although the results suggest a strong association between many aspects of disadvantaged women's lives and smoking, one must not assume that they 'cause' smoking in a direct sense, but may be mediated. For example, as Marsh & McKay show (1994), financial disadvantage may be the result of smoking. Moreover, the reported emotional and physical ill-health of many women smokers may be in part due to their smoking as much as it is an effect.

However, Graham does go on to conclude ‘interventions which help reduce the burdens of heavy caring responsibilities and improve women’s material circumstances may lift the barriers which prevent at least some working class women from trying, and trying again to give up smoking’ (p.102). More recently, she has called for social policies to improve disadvantage by levelling up opportunities and living standards as having a part to play in reducing socio-economic differentials in smoking (Graham, Inskip, Francis & Harman, 2006). It is difficult to argue with these goals; surely improving relative poverty might bring down smoking rates amongst disadvantaged groups? As Graham and colleagues themselves acknowledge, however, there is equivocal evidence from both the UK and the US that improvement in financial circumstances necessarily result in improvements in women’s smoking status (Graham et al., 2006). This may be because the move to employment (in the US) for lone mothers is associated with other life stressors such as finding childcare, shiftwork and poor working conditions (Kaplan, Siefert, Ranjit et al., 2005) or because smoking is very entrenched behaviour in the poorest groups (Graham et al., 2006, p. 11). Another alternative, from the smoking trajectories perspective, might be to target adolescents, for example, through improved educational outcomes for disadvantaged young people, as this is a powerful predictor of smoking status in adulthood and difficulty quitting (Graham et al., 2006; Graham & Der, 1999a).

I also think it important to note that one third of the smokers in the original ‘Life’s a drag’ report had none of the six multiple measures of disadvantage. This suggests that although these factors are linked to smoking for some individuals, smoking is also driven and sustained by other factors rather than profound material disadvantage in other instances. Many of the non-smokers in the sample were multiply disadvantaged (18%) as were the ex-smokers who had succeeded in quitting despite their circumstances (28%). That is not to deny the link between material deprivation and

smoking, rather to point out that the link is not simple: some deprived mothers don't smoke, and others quit, so smoking is not an inevitable or immutable coping strategy for all mothers in poverty. This thesis focuses more on the shared discourses surrounding smoking for lower and higher SES smokers and non-smokers as another symbolic 'context' which may sustain or challenge smoking in working-class groups in addition to their material circumstance.

One might also question some of the conclusions drawn from the statistical differences between the groups in the report. For example, there is a statistically significant difference between the amount of heavy smokers (70%) and never smokers (81%) who rated that they felt in control and exercised choice in their lives ($p < 0.05$). It could be concluded from this, as Graham does, that heavy smokers were more likely to feel out of control and the quotes chosen highlight this interpretation. However, although statistically a significant difference, we have to question whether the difference between 7 out of 10 heavy smokers and 8 out of 10 non-smokers is really meaningful here. Actually, what it tells us is that despite living in a situation which looks to researchers chaotic and disadvantaged, most mothers feel in control of their lives and feel they can exercise choice, the non-smokers only marginally more than the smokers.

A final point, which is more a matter of tone, is that this report does tend to problematize lone motherhood and having multiple children. Caring for multiple children in poverty is presented as a profoundly negative experience, reflected in the title 'Life's a drag'. However, many women chose to have many children despite of, or perhaps because of, living in disadvantage. Although they may have unstable relationships, or live on benefits, or live in areas high in crime or be heavy smokers, they have children young and continue to have more children; their multiple caring responsibilities are as much their (limited) life-choice as much as their life-burden. One

reason for this is that for many young women without good qualifications, becoming a lone mother and having more than one child represents a positive life choice in their community. It is also normative; others do it and provide companionship and enjoyment whilst parenting together, perhaps alongside their own mothers as part of an inter-generational experience of young motherhood. Furthermore, it represents a positive source of identity and positive self-esteem; the teenage mother can characterise themselves as a 'good mother' who cares for their child '24/7' (Graham & McDermott, 2005). Furthermore, as Chodorow (1978) pointed out nearly thirty years ago, mothering is also perceived by many as a means of gaining an intimate bond or unconditional love with another, particularly in the context of unstable adult relationships; the child is 'someone who will love me and won't leave me'.

Graham herself has written about the tendency in quantitative studies to problematize teenage motherhood and see it as a route to social exclusion whereas recent qualitative research with teenage mothers shows that it is an act of social inclusion and they often receive considerable support from family and friends for this life-path (Graham & McDermott, 2005; McDermott & Graham, 2005). It is interesting to consider how smoking might intersect with beliefs about 'being a good mother', asking how smoking might be sustained or challenged from this mind-set, rather than simply considering lone motherhood in poor material circumstances as necessarily being a negative experience. Despite these reservations, there is no doubt, however, that Graham's early qualitative work was seminal in helping to shift health professionals away from thinking in terms of a solely health risk orientation in relation to smoking.

2.4.2.2 Further qualitative research into smoking and disadvantage

A further body of work has considered the experiences and understandings of disadvantaged smokers, both men and women, to show how their daily experiences may

be intrinsically linked to their smoking patterns (Bancroft, Wiltshire, Parry and Amos (2003; also Wiltshire, Bancroft, Parry & Amos, 2003). The sample for the Smoking and Disadvantage study came from two health centres located in disadvantaged areas of Edinburgh, which were in a poor state, with few local amenities. They note the difficulty in recruiting research participants in disadvantaged areas, although this appears to be as much the result of incomplete records as a desire to avoid participating (Parry, Bancroft, Gnich, and Amos, 2001). 100 interviews were conducted in total, with 50 females and 50 males from 25-40 years of age. They were interviewed using an adapted 'life-grid' which asks respondents to detail their smoking behaviour during one day across their different life domains (such as work, home, leisure), focusing on the patterns of their behaviour including any variations on contrasting days. As with Laurier (1999), the emphasis is on the co-construction of the grid between interviewer and interviewee. Their analysis developed a profile of typical smoking behaviour for each interviewee, focusing on how this emerged in the context of the routine events and circumstances of the day.

In the first paper, already discussed in Section 2.2.6, Bancroft et al., (2003) found that participants did not use the terms 'habit' and 'addiction' inter-changeably, but rather assumed different meanings at different times of the day in different contexts. For both men and women, the patterns of their behaviour are mostly explicable by the different contexts in which they inhabited, such as child-care or work, rather than any difference in motivation. They also argued, in line with Graham (1993) that this type of smoking is linked to the context of disadvantage, particularly in coping with a life in which high stress and boredom is a constant feature.

In the second paper (Wiltshire et al., 2003) the focus is on the perceptions and experiences of quitting in the same sample. Their results indicate three major reasons to

quit; health, cost and 'significant others'. The role of 'significant others' is particularly interesting, as although most participants didn't report having quit as a result of their pressure, they did report moderating their smoking behaviour, which was often a source of difficulties within relationships with both partners and children. They also made a link between stress and difficulty quitting; often stressful periods prompted a relapse. Relapse was also connected with the 'culture of smoking' which exists despite (large) work-place restrictions in Scotland, where smokers congregate together outside work and socialise together. Participants related their inability to quit or stay stopped to their environment or context in a number of ways; either the high number of smokers around them, or the stress of caring for children, or because of the difficult, crime-ridden surroundings and unemployment. Thus finding the 'right time' or the 'ideal conditions' was particularly problematic for the disadvantaged smoker. This exacerbated feelings of 'addiction' to cigarettes; the sense of being 'trapped' by both place and physiology.

The 'life-grid' approach used in these papers has many merits. It anchors smokers' beliefs and perceptions in the concrete experiences of a typical day. It also allows the contextual aspect of the data to be investigated. For this reason, an 'episodic' style of interview, which aims to tap 'episodes' or 'experiences' from the domains of ordinary life, such as work, home-life and friends-relationships and leisure-time, is used in the interview study in this thesis. Again, the intention is to anchor the understandings of smoking within the experiences and contexts in which they are produced.

It is also important to note that for more disadvantaged smokers, their patterns of smoking may have become entrenched earlier on in their smoking careers than for more advantaged smokers. Another qualitative study by Wiltshire et al., (2005) shows that for adolescents in their mid-to-late teens (16-19 years old) who were unemployed on leaving school, smoking was already enmeshed in their daily lives, in the same way as it

is for adult smokers living in deprivation (Bancroft et al., 2003). As smoking functioned as an acceptable identity for them in this new context, they were more likely to be regularly smoking as part of an established smoking culture. They also identified boredom, and the despondency, of being a young unemployed person as key drivers of their continued and entrenched smoking behaviour. Although other more advantaged groups of late teenagers in the study, such as those attending university, also perceived their smoking to be increasing in relation to their newly established freedom and new social contexts, ultimately this is a group more likely to leave university into workplaces which, in Scotland and England, will be non-smoking in the future. No such transition into a no-smoking world is likely to occur for those who are unemployed by their late teens, establishing them as regular, and heavier, smokers earlier in their smoking careers with all the implications in terms of health effects and difficulty quitting that this implies (Jarvis & Wardle, 1999).

Another approach, by Stead et al., (2001), considers how the geography of disadvantaged 'areas' might contribute to higher smoking rates, over and above the factor of individual low socio-economic status. Their study was prompted by the finding that there are 'area effects' for smoking rates even when individual SES is taken into account (e.g. Shohaimi et al., 2003). They conducted focus groups with 18-24 and 25-44 year olds who were at different points in the 'Stages of Change' model. The participants were drawn from three Glasgow communities which have very high DEPCAT (Deprivation index) scores with a smoking prevalence of 56%. Their results show that smoking can be fostered in multiple ways by living in an economically, culturally and physically isolated community. For example, many participants were coping with unemployment which left them with 'time hanging heavy on their hands' (p.337) which they felt led to increased day-time smoking. There was also isolation from wider social norms, particularly pro-smoking community norms, as a result of

physical and social disconnection. Furthermore, some of the positive attributes of social capital in these communities, such as neighbourliness and attachment to the area, in fact reinforced smoking culture through behaviours such as pooling limited resources such as 'fags'. They concluded that smoking may compensate for, yet reinforce, some of the negative feelings of exclusion and stigmatisation which adversely affect the mental health of disadvantaged communities.

Their research makes many valid points about the possible routes through which poor structural contexts might contribute to high smoking rates. However, one might question whether perhaps this social isolation is given too much explanatory weight for two reasons. Firstly, the particular geographic areas they have picked, in the form of housing estates, are quite isolated; however, not all working-class or disadvantaged people live in isolated housing estates, and those that do, may well shop and work in central parts of their towns and cities, and thus encounter prevailing non-smoking norms and communities. The paper by Bancroft et al. (2003) shows that even those living in very disadvantaged communities have restrictions on their smoking, whether through work, travelling on public transport, or through not smoking directly in front of their children. Secondly, the emphasis on geographical isolation does not take account of the commonalities of experience and knowledge across structural contexts. For example, medicalized media/institutional representations of smoking as a health issue (e.g. Penn, 1999) may be shared by those who read the same red-top newspapers and watch the same TV programmes. They do make the very valuable point, however, that social isolation is reinforced by smoking as well as perhaps caused by it; as smoking becomes more and more unacceptable in wider society, lower SES smokers carry another barrier to integration.

Taken together, these qualitative studies provide considerable evidence that living in a disadvantaged community encourages starting smoking and creates barriers for quitting and staying stopped. As Wiltshire et al., (2003) state ‘in many contexts which they inhabited it was easier to be a smoker than a non-smoker’ (p.301). Nevertheless, even in areas with very high smoking rates, such as the one studied by Stead et al. (2001), a large proportion of the population doesn’t smoke (44% in this study). Furthermore, as Graham (1993a) shows, although some may be relatively advantaged in their communities, a good proportion of non-smoking and ex-smoking mothers live in equally disadvantaged conditions. This raises questions about what it is about these individuals or sub-groups of non-smokers, or the ways in which they think, which inoculates them against this smoking culture. In this thesis, lower SES non-smokers as well as smokers will be interviewed as these provide an interesting comparative group; it is hoped a nuanced analysis of their discourses and understandings might illuminate how some individuals create resistant identities in the dominant ‘smoking worlds’ of the disadvantaged.

This thesis also considers the experiences and understandings of higher socio-economic groups. As Bancroft and colleagues say about their paper on addiction and habit, ‘although many of the themes and issues we have identified would be relevant to smokers living in better circumstances, they appear to be especially salient for disadvantaged smokers’ (Bancroft et al., 2003, p. 1267). It is argued here that although there is considerable merit in going in-depth into the understandings and experiences of one particular population, such as lone mothers, or disadvantaged men and women, there is also merit in stratifying the sample to include higher SES smokers and non-smokers, precisely to start to explore and highlight both commonalities and differences in the way that smoking is understood in different class groups.

To take an example, Laurier (1999) in an in-depth account of one smoker (Harry), has suggested that stress may be a strongly salient explanation of smoking for middle-class smokers as well as lower income smokers. Using a conversation analytic approach, he found that Harry, a middle-class home-owner, used several stories concerning stress (such as his experience of death and loss at his brother's funeral after his sudden death) and his long night-shift work to build a sense of entitlement to continue smoking. Harry shows how cigarettes have assisted him in achieving health in the face of these life-stresses and allows him, on some occasions, to disregard the social duty to be healthy. This thesis aims to try to tease out how common accounts, such as smoking because of stress, might be played out differently in middle or working-class contexts.

Finally, several researchers have argued that an interdisciplinary approach may be the way forward for studying disadvantaged smokers (Parry, Amos, Bancroft and Wiltshire, 2002). This is also the implication of the Health Action Model of Tones (1998) reviewed in section 2. In an editorial piece (Parry, Amos, Bancroft and Wiltshire, 2002), these authors draw together three research perspectives which have contributed to the understanding of why smoking is linked with social and material disadvantage. The first of these is the 'nicotine' addiction approach which emphasises the differential variation in nicotine intake amongst lower SES groups (e.g. Jarvis & Wardle, 1999). The second strand, from a sociological perspective, focuses on the social and material circumstances of the disadvantaged which might explain their smoking behaviour. The work of Graham which focuses on studying lone mothers in particular exemplifies this approach. The third approach is the psychological one, which focuses on social cognition models such as self-efficacy theory (Bandura, 1992) which emphasise the control which smokers have over their behaviour. It has been argued that the addiction discourse is disempowering as it encourages 'fatalism' amongst smokers (Gillies & Willig, 1997); fatalistic discourses have also been linked with SES. Parry et al., argue

that in order to combat smoking amongst disadvantaged groups, inter-disciplinary approaches are needed which examine the ways in which combining factors such as nicotine addiction, poor social circumstances and lower self-efficacy might lead to higher smoking rates.

It is difficult to argue with the call for a more inter-disciplinary approach. However, it is not that researchers are being perverse by not including other disciplines. Often, at a theoretical level, it is hard to include different 'level' variables. For example, in health psychology, social cognition models which are primarily individualistic have difficulty in including 'macro-social' factors such as socially shared beliefs or structural circumstance (Joffe, 1996). They are often acknowledged as important, for example, although the primary focus of Jarvis & Wardle's work is focused on nicotine levels and SES, they also argue that cultural beliefs are important in understanding the links between disadvantage and smoking (1999). However, given a lack of theory with which to study them, research tends to use the same delineated and separate paradigms.

Although this thesis does not take an inter-disciplinary approach, it does consider how social psychological approaches, particularly drawing on social identity theory, can help uncover the ways in which the 'macro-level' of symbolic beliefs, norms, culture and structural/material context are evidenced within the 'micro-level' individual thinking of those in different SES groups. To do this, it draws on theories from outside social psychology, primarily from cultural theory and addiction research. The next chapter outlines the theorisation of this approach.

2.5 Conclusion

The psychological literature on smoking is vast. This review chapter has identified three strands of psychological research into the theorisation of class differences in smoking, each aligned to a different paradigm. It has been argued that the research on class

differences in each paradigm has taken one so far but no further in accounting for the 'poor smoker' phenomenon. It has been further argued that there is a particular need to consider the psycho-social meanings of smoking cigarettes in different class groups in the light of the strong social patterning of this behaviour. The next chapter goes on to consider how other social psychological theories such as Social Identity Theory (SIT) and the work of Crawford (1994) and others might be usefully drawn on to this end.

CHAPTER THREE:

THEORIZATION OF THE PSYCHO-SOCIAL IDENTITIES OF ‘BEING A SMOKER’

3.1 Introduction to the theorisation in this thesis

The overall aim of this thesis is to investigate the current social meanings of being a smoker in different socio-economic groups in England. The review of literature in Chapters One and Two has revealed a considerable under-theorization of psycho-social factors in the class-smoking phenomenon. It is argued, therefore, that this thesis must look elsewhere for its theoretical basis, particularly towards social psychology. One theory that will be drawn on is ‘Social Identity Theory’ (SIT) (Tajfel & Turner, 1986). In particular, the focus will be on recent re-conceptualizations that see social identities, and the meaning-systems that underlie them, as constructed in response to social context (Campbell, 1997; 2000; 2005). A second key theory for this thesis is that of Crawford (1994). He suggests that having a healthy identity is core to Western identity as health has become a virtue in its own right, embodying essentially middle-class social values such as discipline, control and responsibility. A third strand of literature addresses the notion of addiction, in particular the concepts of an ‘addictive personality’ from clinical psychology and ‘addict identity’ primarily from sociology. A fourth strand derives from the stigmatisation literature, in particular that which takes account of the social meanings and contexts of stigmatised identities. These four strands provide a theoretical springboard from which to consider smoking identities in adults from different socio-economic backgrounds. At the end of Chapter Three, the specific research questions that emerge are outlined.

3.2 Theorising smoking as a social identity

3.2.1 Social Identity Theory/Self-Categorisation Theory

The theorisation of 'identity' is extensive within psychological research. The term 'ego identity' was originally introduced to the social sciences by Erikson (1946). It was originally hypothesised to comprise two parts. The first, 'personal identity', is the enduring sense of self that an individual has across the life span. This self has qualities that are considered individual, such as personality traits. The second, 'group' or 'social' identity is the sharing of significant characteristics with others. It is defined as 'that part of the individual's self-concept which derives from their knowledge of their membership of a social group (or groups) together with the value and emotional significance of that membership' (Tajfel, 1981, p255).

One branch of Social Identity Theory (SIT), 'Self-Categorisation Theory' (SCT) suggests that personal and social identities are not qualitatively different forms of identity, but simply different ways or levels of categorising the self (Tajfel & Turner, 1986). According to Tajfel and Turner, people can categorise themselves according to three broad dimensions rather than just two: as part of humanity in general (superordinate level), as part of specific groups (intermediate level) and as individuals (subordinate level). They suggest people have a multiplicity of social identities (e.g. one can be simultaneously a union member, Irish, an accountant, a daughter, a smoker and so on). This identity is not fixed, but fluid and determined by inter- and intra-category differences that emerge in a social context. What is perceived as a difference in one context can be a commonality in another and what is salient in one context may not be important in another. For example, the identity of being a daughter in the context of visiting one's family may be highly important. However, this identity may be much less important at work.

Social identity not only defines how you see yourself, but also how other people see you. It is a 'category-based' rather than individual level of processing (Tajfel & Turner, 1986). Things that are associated with a particular group, whether negative or positive, come to be associated with them as members of that group. Membership of that group can thus be considered a 'signifier' for other people. Clearly, therefore, being a member of a group is not a value-neutral position. Emotions, values and judgements are made about people on the basis of their (perceived) group membership (Tajfel & Turner, 1986). The interest here, therefore, is to consider the psycho-social significance of identifying oneself and others as 'smokers' in different SES groups.

SIT has hypothesised many psychological processes at work between in-groups and out-groups (Tajfel & Turner, 1986). It is argued that, in most instances, people wish to maintain a positive social identity through favouring their own group ('in-group bias') and considering them superior. This results in higher self-esteem for group members, although as Brown, in a review of SIT notes, there are multiple other benefits of belonging to a group, such as social interaction opportunities or self-insight (Brown, 2000). Social comparison processes are key to maintaining a positive identity, for example, group members might have self-supporting thoughts and emotions such as 'we're better than them'. Another process that can support identity is differentiation, drawing clear distinctions between 'them' and 'us'.

It is clear that it is easier for high-status in-groups to achieve positive social identity, gain higher self-esteem, and in doing so potentially maintain their elevated level in the social hierarchy through these processes than for low-status subordinate groups. Lower status group members have to psychologically manage the fact that they may be considered negatively in comparison with others. They require, therefore, different identity maintenance strategies (Ellemers, 1993). One such strategy for an individual is

simply to leave the group. A pre-requisite for this is a belief in 'social mobility', or the ability to permeate and cross group boundaries. Trying to 'better oneself' in terms of money or social status, or becoming a non-smoker, is an example of this response. A less dramatic response is 'dis-identification' with the subordinate group; simply not identifying oneself with it too strongly. An alternate strategy is to attempt social change by changing the status of the out-group (Tajfel & Turner, 1986). One way to do this is to bolster or re-create the existing social identity (social creativity). Out-groups might, for example, introduce a new dimension on which they compare favourably. Another potential response is more direct, to challenge the dominant group in a collective assertion of rights.

Other strategies have recently been suggested within SIT research (Brown, 2000). Individuals in lower-status groups might use perceptions of group variability to mitigate poor status (e.g. 'even if some smokers are unhealthy, we are not all unhealthy'). To this end, exemplars which do not fit the stereotypical mould may be drawn upon. There is some evidence that this occurs in the context of health as everyone appears to know an 'Aunt Sally' or 'Uncle John' who drank and smoked 40 a day, yet lived until they were ninety. Another strategy is to split the lower status group into categories, so that an individual sees himself/herself as a member of a 'superior' lower status group (Brown, 2000). This is another form of social comparison, illustrating the point that everyone, even within lower status-groups, can usually find a group of people who they consider to be 'worse' than themselves. A final strategy, little explored in SIT/SCT, is for lower status groups to accept their negative derogation. A weakness of SIT is, however, that it does not predict which situations provoke which strategies amongst subordinate groups (Brown, 2000).

Given the emphasis on the social context of inter-group processes in the original theory, it might be thought that real-life groups would constitute the field of exploration within SIT research. However, this has not been the case. Much of the empirical work that has developed SIT/SCT theory has used the minimal group paradigm, in which group membership is assigned in an experiment by the researcher on the basis of minimal characteristics. This has led to criticisms of the low ecological validity of the theory (Schiffman & Wicklund, 1992, Campbell, 1997; 2000). It is argued that these ‘minimal groups’ are not phenomena that occur outside a laboratory. It is problematic, therefore, to extrapolate from this data to naturally occurring groups. Nor is it clear that the ‘identities’ which subjects are assigned in these experiments are identities that are important to people outside the laboratory context. Mindful of this criticism, perhaps, there has been a recent increase in ‘real-life group’ research within the SIT paradigm (e.g. Hinkle, Fox-Cardamone, Haseleu, Brown & Irwin, 1996; Brown, 1999). However, in general the criticism still stands: the dependence on experimental paradigms conducted in the laboratory has led to the neglect of the impact of social context in developing and maintaining social identities (Campbell, 1997; 2000).

In response to this critique, SIT/SCT has been reworked within a constructivist perspective by Campbell in the area of health psychology, specifically in relation to HIV/AIDS related behaviour (1997; 2000; 2005). Campbell argues that within dynamically changing social situations, different groups have different life challenges to meet. They do this functionally through what are termed ‘recipes for living’. These comprise sets of behavioural possibilities and constraints (e.g. norms or lifestyles) concerning health. They are also managed through repertoires of interpretative frameworks (such as meaning systems, shared scripts or mental models), through which all behaviour and experiences are understood. The point is that social identities are constructed within a given situation and can be understood within it. The example that

Campbell gives is the seemingly inexplicable health behaviour of unprotected sexual intercourse within a high risk HIV population working in the South African gold mines. She shows that, in fact, this behaviour offers an opportunity for physical intimacy (skin-to-skin) in an isolated and dangerous environment. In this context, the risk of contracting HIV is not the most important factor driving the health behaviour (Campbell, 1997).

The social context of health practices, and the social identities that underlie them, is thus all important in understanding them. As outlined in the introduction, context is understood to have three interacting dimensions (Campbell, 2005). The first is symbolic, the socio-culturally situated beliefs about the group; this is the focus in this thesis. The second is the organisational context, for example, including governmental, research and therapeutic communities. The third is the material-political context, such as poverty. From this perspective, social identities, and the health practices linked to them, often 'make sense' for the people living in those complex social contexts (also see Radley, 1994). The definition of context in relation to the creation of smoking identities was considered in more detail in Chapter One.

Given SIT's pre-eminence as one of the key theoretical perspectives of social psychology, it might be expected that much research into smoking identities in adulthood might have taken place. However, far more attention has been paid to the social identity of adolescents with regard to smoking, which the next section now reviews.

3.2.2 Adolescent identities and smoking

A significant body of literature has considered smoking in terms of identity during adolescence (e.g. Lloyd & Lucas, 1998; Mitchell & Amos, 1997; Aloise-Young &

Hennigan, 1996; Leventhal & Cleary, 1980; Banwell & Young, 1993; Wearing, Wearing and Kelly, 1994; Paavola, Vartiainen & Puska, 1996; Luke, Allen, Arian, Crawford, Headen et al., 2001; Johnson, Lovato, Maggi, Ratner, Shoveller et al., 2003; Denscombe, 2001; Moffat & Johnson, 2001; Plumridge, Fitzgerald and Abel, 2002; MacFayden, Amos, Hastings & Parkes, 2003; Stjerna, Olin Lauritzen & Tillgren, 2004; Wiltshire, Amos, Haw and McNeill, 2005; Amos, Wiltshire, Haw and McNeill, 2006.

This section reviews some of these studies.

Leventhal and Cleary (1980) suggest that the potential adolescent smoker passes through a phase in which they evaluate the image of smoking and smokers. A positive image evaluation is likely to lead to smoking as a way of achieving this desired identity. It thus functions as a behavioural tool in the formation of adolescent identity (Lloyd & Lucas, 1998). Smoking is thus a behaviour which can be taken up as part of a new image or identity, such as changing clothes. Several qualitative papers have also suggested that there may be different psychosocial functions regarding social identity for young males and females with regard to smoking. Mitchell & Amos (1997) investigated smoking, gender and peer group structure using a longitudinal study including both qualitative and quantitative data collection with 11 and 13 year old boys and girls. They found that teenagers spontaneously placed themselves and others within a hierarchical 'pecking order'. Smoking was particularly associated with 'top girls' as part of their image and identity as cool and attractive. Top boys were less vulnerable to having to smoke for this reason, particularly as exercise and sport seemed to provide an alternative route to popularity instead of smoking. 'Middle' girls did not tend to smoke and went around in no-smoking groups who reinforced each other's decision not to smoke. A few 'low' status pupils were vulnerable to the pressure to smoke, or even coercion. They conclude that the meaning and salience of smoking in the daily lives of girls appeared to differ, depending on their social status. Smoking was enmeshed with

issues of being a 'top' girl, and the required social identity of being seen to be rebellious, cool and sophisticated. They argue that these findings support the 'provocative hypothesis' (Clayton, 1991) which suggests that girls who smoke may be characterised by high self-esteem and good social skills rather than the other way around.

One reason may be because this marks them out as separate from the 'good' identity of the 'middle' girls in the pecking order who are relatively conformist and have more traditional 'feminine' (good, polite, adult-oriented, seeking approval) identities (also see Banwell & Young, 1993). Wearing, Wearing and Kelly (1994) conceptualise thinking about smoking in young people in terms of leisure activities. During adolescence, leisure spaces are somewhere where evolving and developing identities can be tried out. For boys, an active involvement in sport is associated with a strong, aggressive, 'hero' image, whereas for girls, withdrawing from sport to concentrate on one's appearance and image is important for identity formation. In this conceptualisation, smoking can be understood as an element in the resistance through leisure of some girls to a traditional 'feminine' identity in which the girl is conformist and passive. Furthermore, smoking can also be understood as a creative and pleasurable (if undesirable) response to the school system which aims to subjugate girls into this passive 'good girl' type.

It is important to note, however, that these studies are culturally and historically situated. For example, Wearing et al., (1994, p. 631) cite a study from the 1980's by Lesko in an American Catholic school in which the 'rich and populars', who are the relatively conformist 'good girls', do not smoke, but the 'burn outs' do, as a sign of resistance. However, in the Mitchell & Amos (1997) study, it was precisely the most popular girls who did smoke, because in this particular setting (Scotland, mid-90's), smoking was a sign of high status, being 'cool' and sophisticated whereas it was the

'middle' status group who were the most conformist. As the signs and meanings surrounding smoking change, so do the social identities which smoking is taken to signify for adolescents.

Furthermore, Plumridge, Fitzgerald and Abel (2002) argue that it is not only being a smoker is an important social identity for adolescents, but not being one as well. They understand identity in terms of 'performativity', in line with the idea that identities are created through what we do, rather than expressions of who we are. Their sample consisted of six small focus groups of 14-15 year olds in New Zealand. Smoking for these participants was linked with both high and low social status. The 'cool' group who smoked were also competent at other areas, such as wearing the right clothes. For the 'low-lives', smoking did not so much enhance their status as demean it, being associated with being looking scruffy and not clean looking. For 'try-hards' who wanted to be cool, smoking was a potential tool for achieving this, although the danger was that one simply looked as if one was trying too hard. Self-assertion of being a non-smoker immediately located the young person as between the two extremes, as being 'average'. For boys, there were other available 'cool' identities which centred on being physical and playing sports, so they were able to challenge the smoker cool through these. The girls, however, lacked a credible alternative to the smoker cool, and therefore tended to continue to idealise the glamour of this group and accept themselves as socially subordinate. Plumridge et al., thus conclude, 'smoking uptake and smoking refusal are both important identity statements... smoking is a signifier of status that has to be either embraced or rejected, but cannot be ignored' (p.168).

This is an important point to make. It is likely that if being a non-smoker is an important signifier in adolescence, it will continue to be in adulthood, particularly as the signs and meanings of being a smoker change, and the ideological meaning of those signs. The

interview study here considers the perspectives of non-smokers (as well as smokers) from lower and higher SES groups. It is argued that refusing to become a smoker and continuing not to smoke in adulthood is a signifying social identity in its own right, particularly in relatively deprived context in which smoking is a social norm.

Denscombe (2001) offers a further interesting perspective on the creation of adolescent smoking identities by taking what he terms a 'voluntaristic' approach. He considers what the benefits of volunteering or choosing to smoke might be in the socio-cultural context of late Modernity which requires adolescents create their own identity, to find out 'who I am', rather than simply follow social norms of peer pressure. The study comprised two phases, a questionnaire phase followed by focus groups (n=123) and a set of semi-structured interviews (n=20). He found that, from the perception of these young people, smoking was less motivated by wanting to look mature (though it was associated with being older) and more by wanting to 'look cool'. It also carried connotations of 'looking hard' or 'big', especially for some girls who were now more willing to compete with boys in terms of being tough within a newly developing 'girl culture'. Smokers also perceived themselves to be 'in control' of themselves and taking charge of their own life, making their own decisions and destiny in the face of their knowledge about the health risks. They also saw life as inherently uncertain; therefore smoking was a 'calculated' risk which people had the choice of making, even if they personally did not do it.

Denscombe argues that in addition to providing self-image in adolescence (as with Lloyd & Lucas, 1998), smoking also functions to enhance self-empowerment and self-affirmation. Thus, for example, he argues that in the culture of 'girl power', smoking would seem to play an additional role in signifying independence and equality for young female smokers, beyond the coping mechanisms it offers (e.g. Graham, 1987;

1993a). Smoking offered adolescents a sense of control, of making one's own choices in life. It made the smoker feel 'special' or just a bit different by being someone who could 'hack' it in the face of the uncertainties of the risks, rather than someone who worries too much about safety. By choosing to smoke, people choose to step aside from the health discourse in which the imperative is to be health, and the ill/sick are perceived as weak and morally inferior (Crawford, 1994). Smoking 'works' for many young people in terms of self-affirmation of being an independent person who chooses what they do and when they do it. It thus fits with the contemporary social ethos for many young people.

This is a particularly interesting paper, as it considers the creation of smoking images and identities in relation to the context of the competing health and autonomy discourse of late modernity. It is unclear whether a similar symbolic understanding of smoking, as a method of self-empowerment and being in control, might be found for some adult smokers (alongside more traditional notions of smoking as an addiction which renders the smoker powerless). What Denscome says, however, is correct: 'smokers in the context of the health discourse of the late twentieth century run the risk of embracing an identity which, whatever it means to themselves and other smokers, is seen as bad by others' (p.173). At some level, the young may be 'excused' from some of the choices that they make, or at least they are interpreted as part of the 'normal' phase of teenage experimentation and search for self-identity. The pressure for adults is different; one's identity, complemented or not by smoking, may be more certain, but it may not be more 'acceptable'. This thesis aims to explore how adult smoking identities might be created in such a symbolic context.

Another interesting study suggests a link between the social contexts of the transition to adulthood (from school and the peer group to work, further education or

unemployment) with smoking behaviour and identities (Amos, Wiltshire, Haw and McNeill, 2006; Wiltshire, Amos, Haw and McNeill, 2005). The starting point of this research is the notion that smoking behaviour can be flexible into the late teens rather than 'set' in early adolescence, with some smokers starting to smoke or stopping, others continuing with social or experimental patterns between the mid to late teens (e.g. West, Sweeting & Ecob, 1999). The study took the form of 49 (mainly) paired interviews with 99 16-19 year old Scottish smokers. It included a diversity of social and educational backgrounds and included regular/daily and social/non-daily smokers, although it was weighted towards disadvantaged smokers who had left school and were either in low paid jobs or who were unemployed.

They found that at this life-stage, some participants did not define themselves as smokers for a number of reasons; either they smoked primarily in social situations (yet daily), or were cannabis smokers, or simply because their smoking was not heavy enough to constitute being a 'proper' smokers. For others who defined themselves as 'proper' smokers, they identified the indicators of this transition, such as being unable to stop. Although the interviewees did not all have the same occupation (college, university, work or unemployment), all felt that their smoking eased the transition into these new worlds by enabling them to be sociable, by giving them confidence, and indicating their belonging. Additionally, they perceived it helped them cope with the new stress of the transitions. For those at university or college, smoking appeared to have lost its meaning as a 'cool' or 'bad' behaviour indicating rebellion. Rather it was a way of punctuating the day, particularly in the context of a lack of structure and freedom to determine one's own time. For those at work, their participation in smoking was determined by whether it was a no-smoking or a smoking workplace; for those where it was permissible to smoke, it encouraged them to embrace smoking culture

further. For those who were unemployed, their smoking was associated with the despondency of being unemployed and unfilled time in which to smoke.

It was thus concluded that the social contexts in which older adolescents inhabit can facilitate or hinder smoking behaviour. Where smoking functions as an acceptable identity in familiar or new contexts, smoking increases. It provides the adolescent with a sense of self-affirmation and peer affirmation (rather than being the result of peer pressure) through behaviour such as sharing cigarettes. Where consumption is restricted, and by implication smoking is not an acceptable identity, consumption may be moderated. They conclude that for this reason, smoke-free policies in workplaces, educational and leisure facilities would hinder the move from social to regular smoking.

This is an interesting paper as it highlights how identities related to smoking are afforded, or restricted, by the social contexts in which people live. It is also interesting to note that the pattern of regular smoking amongst the unemployed young people seems set from late adolescence. It also suggests that the sense of the self as a smoker may yet be fluid in late adolescence. This is also argued by Moffat & Johnson (2001) who identified three narratives, the 'invincibility' narrative, the 'giving in' narrative and the 'unanticipated addiction' narrative in the conversations of adolescent girls who smoked. Although they represent consecutive steps in the process of moving from occasional or 'social' smoking to what is perceived as addictive smoking, the narratives are often interwoven by participants. They argue that smoking cessation should tackle teenagers whilst they are still in touch with the resistant identity of the 'invincibility' narrative, before smoking is integrated into the sense of self.

This section has reviewed some of the literature on social identity, adolescence and smoking. In line with a 'life-course' approach to smoking, this literature is drawn on

throughout the thesis, for example, to consider the continuities and discontinuities between adolescent and adult smoking identities.

3.2.3 *Smoking identities in adulthood*

It is interesting to consider why the vast majority of social identity research into smoking has taken place with adolescents. It might be argued that this is appropriate because adolescence is a key time for identity formation, when one's sense of self and group membership is uncertain and developing. Once one reaches adulthood, it is addiction that drives smoking (see Chapter Two for a form of this argument). However, there are several reasons to challenge the premise that social identities are not relevant to adult smoking. Firstly, according to SIT, identity is something that is constructed and reconstructed throughout adulthood, across the whole life-span (Turner & Tajfel, 1986). Just because adolescence is a key time of identity development does not mean that social identity processes are irrelevant to adult smoking. Secondly, the proliferation of pro- and anti-smoking web-sites (such as www.smokersunite.com, www.ash.co.uk) and the vociferous debate about recent legislation banning smoking in public places in Scotland, Ireland, Italy and now in England suggests that many people view being a smoker as a highly salient group membership to attack or defend. Thirdly, as argued in Chapter Two, believing smoking to be highly addictive does not preclude the notion that smoking also functions at an identity level. The two are not mutually exclusive theories. Fourthly, social identities may exist independently of our intentions. Adult smokers may not consciously choose to use smoking to promote a certain social identity. However, other people may well consider it to be a highly salient factor on which to make social judgements (e.g. Furnham, Simmons and McClelland, 2000). Finally, because teenage smoking functions as a way of maintaining social status in an environment where being grown-up and sophisticated is highly valued (Mitchell and

Amos, 1997), it is interesting to consider what happens to smokers' identities once they finally reach the adulthood they imagine smoking to symbolise.

A few studies have examined smoking in terms of group membership. Echebarria-Echabe and colleagues, working within the experimental SIT tradition, found that when they generated conflict between smokers and non-smokers, the representations held by smokers became more defensive. They theorise that this may be because these representations have an identity-protective mechanism for smokers when they feel under attack (Echebarria-Echabe, Fernandez-Guede & Gonzalez-Castro, 1994). Although in this instance the conflict was generated experimentally, recent qualitative research with Scottish smokers and ex-smokers has also found that for the vast majority of interviewees, smoking is an activity linked to notions of belonging to a group, the 'smokers' group' (McKie, Laurier, Taylor and Lennox, 2003). Collins, Maguire and O'Dell (2002) also identify a sub-group of smokers who see smoking as a 'social tool' and thus an important part of their social self. Although limited in number, these studies suggest that group identity may be important in the context of adult smoking. However, to the best of the author's knowledge, no research has been published which specifically focuses on the creation of smoking identities amongst participants with different socio-economic backgrounds.

In line with Campbell, there is a strong focus in this thesis on the contexts in which smoking identities are produced. Some research has considered college students and adult smokers' self-identification with smoking. This has taken the form of attitudinal scales, containing items such as 'I see myself very much as a smoker' which are thought to tap self-concept in relation to smoking (e.g. Freeman, Hennessy & Marzullo, 2001). However, as argued in Chapter Two, research using such scales has been critiqued as individualistic and lacking any consideration of social context (Joffe, 1996).

It is also interesting to note that of the studies that have explored the cultural context of smoking, few have examined the contexts of middle-class adult smokers. Groups studied have tended to be 'Other' (such as Vietnamese (Morrow, Hong Ngoc, Trong Hoang, Hue Trinh, 2002) Chinese (Jarvis & Wardle, 2000, p. 41) or Swedish, (Stjerna et al., 2004)) women (Morrow et al., 2002; Graham, 1993a; 1993b. 1994; 1998), the young (Stjerna et al, 2004; Lloyd & Lucas, 1998) or working class (Graham, 1993a; 1993b, 1994, 1998; Bancroft, Wiltshire, Parry & Amos, 2002) smokers. This may be because, at a material level, smoking particularly prevalent amongst these groups. However this is certainly not the case for women as more men smoke. It may also be pertinent that these groups often represent the 'Other' for researchers and thus are seen as having a distinct 'identity' to study. This thesis considers the identities of *both* middle class and working class English smokers (and non-smokers) and aims to consider the commonalities as well as the differences across class.

SIT also posits that emotions and values are attached to group membership. Thus the emotions, values and judgements attached to smoker's identities are also considered in this thesis. Some research has already delineated some potential associations. The work by Eiser reviewed in Chapter One suggested that people may make different attributions based on whether someone is classified as a smoker (Eiser, 1978a; 1978b). Furnham, Simmons and McClelland (2000) have also shown that subjects favour non-smokers in a decision-making task concerning the hypothetical allocation of medical resources. They suggest that participants use a utilitarian moral ideology in this context in which groups such as smokers are considered undesirable or unworthy. Social identity is therefore a highly relevant way to evaluate the understandings of smokers and smoking amongst lower and higher SES groups, where these values may also differ.

3.3 Smoking and healthy identities

Smoking identities in this thesis are not considered in isolation. Rather it is argued that smoking is only one dimension of identity amongst many others, and that it is in the interaction of these identities where the interest, and often the conflict, lies. Another identity theorised to be relevant here is one which has been strongly associated with class: being healthy (Crawford, 1977; 1980, 1985; 1994). Crawford's starting point is that the concept of health is absolutely central to modern identity. Health is not just a biological state of being, but a social arena in which we display who we are. This is because health has come to signify certain key values in our society, primarily those of control, self-discipline and individual responsibility. Being 'healthy' has become a marker of moral worth in a secular society. It is a way of distinguishing people who take responsibility for their lives from those who do not. Health constructed in this way is understood as a duty, a social requirement of the individual. It also has a performative aspect. It is not enough to be healthy; one has to be seen to be healthy, to demonstrate it by attending exercise classes, buying organic vegetables, or by giving up smoking.

The group that is seen, or sees itself as the healthiest is the middle-class. Crawford's interviews with sixty middle-class individuals lead him to suggest that their discourses are infused with health consciousness. The health project takes up much of the middle-classes' time, energy and money. In return, it signifies their social worth; their internal control, self-discipline, and sense of responsibility in the face of the endless possibilities for consumption in the consumer culture.

Crawford argues that the process of constructing middle-class social identity on the foundation of health is socially divisive. He draws on the idea of the 'bifurcated' self to explain how this identity process operates. He argues that to identify oneself and one's group as 'healthy', one has to identify other people and other groups as 'unhealthy'. The

'Healthy Self', which is also the 'conventional' and 'dominant' self, needs an 'Unhealthy Other'. However, the boundary divide between being healthy and unhealthy is particularly fragile, making the process of drawing boundaries around our 'healthy selves' more pressing, yet more difficult. Threats to the 'Healthy Self' abound. At its most extreme, disease and death (as embodied in the syndrome of AIDS, according to Crawford) threaten our certainties that illness is controllable in Western society. At a less dramatic, but very pervasive level, our sense that we are constantly 'at risk' makes us feel a permanent vulnerability to health threats. Crawford argues that as a reaction to this fragility of self, we employ a psychic defence, and project disease, illness, and unhealthiness onto other groups of people. This projection is not random, but is usually directed at already stigmatised or less powerful groups, such as working-class people, sex workers, drug users or 'foreigners'. It is they, the 'Unhealthy', who are at risk, irresponsible, out of control or to blame, not 'us', at least from the perspective of the dominant middle-class.

Crawford's seminal theory, which draws on both social psychological and cultural theory, is useful for this thesis in several ways. Although it was originally outlined with respect to HIV/AIDS in the US, it is highly relevant to class differences amongst English smokers. Crawford's proposition is that there is a distinctive construction of health amongst middle-class groups. There is indeed evidence that the understandings of health and the health-smoking link differs between class groups of smokers. Looking firstly at definitions of generic health, D'Houtard & Field (1984) analysed the open-ended responses to definitions of health and linked them to class. For the higher and middle class groups, health was understood as a value in and of itself, with the goal of 'well-being'. For the working-classes, health was understood in more utilitarian terms, as a means to do things, particularly to work.

Calnan & Williams (1991) also conducted a general qualitative enquiry into the meaning of health and health-related behaviour in the contexts of everyday life for a set of 20 households who differed in terms of socio-economic status (10 middle-class, 10 working-class). Both men and women in the households were interviewed. They were asked to talk about their typical day, for example, yesterday, to uncover the salience of health-related behaviour within their life-contexts. They were also asked more specific questions concerning smoking in relation to health, amongst other things. With regard to smoking, they found that although both groups had formal knowledge of the risks of smoking, the majority of working-class participants only thought they would give up when they actually manifested ill-health (e.g. through a 'health scare'), whereas the middle-class participants were more likely to stress the potential risks and dangers for themselves and others such as children. More generally, they found that matters of health rarely surfaced in people's descriptions of their daily lives, although they were discussed vigorously when raised by the interviewer. They suggest, this might reflect that health is only a problem when it becomes a problem, either through its absence when someone falls ill, or because people only tend to discuss topics when they are called into question. It also might be the case that this was not what the participants understood they were being asked to talk about and reflects functional routine-based explanations of daily life rather than more deep-seated psychological drivers.

Chamberlain & O'Neill (1998) have also examined social class differences in the understanding of health in a qualitative sample of smokers from New Zealand. They interviewed 15 lower and 15 higher SES smokers smoking 10 or more a day, with an age range of 21-55. Lower and higher SES was determined by the Elley-Irving socio-economic index of occupation and income; those with professional jobs (levels 1 and 2) being the 'higher' group and those with semi or unskilled jobs (levels 4 and 5) being the 'lower' SES group. Firstly, they found that the meaning of health differed between

participants, with lower SES smokers tending to emphasise functional health, whereas higher SES tended to emphasis both well-being and behaviour in a holistic sense, in line with existing research (e.g. D'Houtard & Field, 1984). Secondly, although both groups perceived themselves to have some control over their health behaviours, it was more consistently mentioned, and in a greater number of behaviours (hygiene, positive state of mind) than simply diet and exercise by the higher SES participants. Lower SES participants were more likely to be fatalistic regarding their health, particularly in relation to smoking (Calnan & Williams, 1991). Finally, although both groups cited habit, addiction and the relief of stress as reasons for smoking, higher SES participants were more likely to say they enjoyed it, whereas lower SES smokers were more likely to express their concern over the embedded nature of smoking in their present relationships and the pressure that this created. They argue that there appears to be greater situational expectations and pressures on lower SES participants to smoke, perhaps through the mechanism of higher stress. They thus conclude that these perceptions 'make sense' in a socio-material context in which lower SES individuals have less control of both physiological and psychological health.

As a whole, these studies suggest that meanings of health and personal control may differ between social class groups. This thesis will consider whether similar differences are found in the UK, and, additionally consider how other aspects of the health discourse concerning morality and identity (e.g. Crawford, 1994) might be drawn on differentially by lower and higher SES smokers and non-smokers. It may be, in line with Crawford's thesis, that middle-class smokers may find a way to exhibit a more control-oriented 'health consciousness' even within their smoking habits.

3.4 Smoking and addiction identities

Another source of literature useful to consider in relation to smoking identities is that concerning 'addict identities'. As was discussed extensively in Chapter Two, bio-physiological addiction is the dominant model used to explain smoking behaviour within clinical and health psychology. Sociological work in particular has conceptualised being addicted to a substance in terms of holding an 'addict identity'. For example, Becker undertook an investigation into the processes underlying adopting an identity as a marijuana user (Becker, 1963). To him, a key part of acquiring an addict identity is learning to interpret the (social) experience of using the substance and developing a favourable attitude towards it (e.g. seeing it as enjoyable, exciting, a buzz). Conversely, recovery involves reinterpreting the addict lifestyle (e.g. as restrictive or needed to maintain normality). Waldorf and Biernacki (1981) argue that recovery can be conceptualised as managing a 'spoiled identity'. A dependent drug user will, according to them, consider an identity shift (to ex-user) when their spoiled identity starts to conflict incompatibly with other identities they wish to hold, such as wife, partner, employee. The person then sets about restoring their damaged sense of self, either by recapturing their old identity, or recreating a new one.

It has been argued in the sociological literature that identity is product of the biographies we produce for ourselves and others (Giddens, 1991). In line with this, addict identities are often seen in terms of the narrative processes underlying them, in particular the journey from being an addict, to a recovering addict to an ex-addict. For example, McIntosh and McKeganey (2000) examined addict recovery narratives and uncovered key points within the stories. One of these was self-reconstruction, whereby the person identifies three aspects of their selves a) the 'real' person they used to be ('at

heart') b) the 'false' person drugs made them and c) the 'ideal' person they would like to be.

This concept of the process or narrative dimension of recovering from addiction is also found in the five-stage model of Prochaska and colleagues from clinical psychology (DiClemente, Prochaska, Fairhurst, Velicer, Velasquez et al., 1991; Prochaska, DiClemente & Norcross, 1992). According to this model of recovery, the individual progresses from a stage of 'pre-contemplation', before the user has considered stopping, to 'contemplation' when he or she thinks about stopping, to 'preparation', in which the decision to stop occurs and efforts are made to prepare for stopping, to 'action' in which specific steps are taken to reduce drug use and finally to 'maintenance', in which non-using behaviour is consolidated and the individual is defined as an ex-addict. Although this model is primarily used within the context of treatment and intervention, it highlights that smoking is a transitional time in terms of personal and social identity. When someone quits, they relinquish this group membership at least temporarily, for example, now becoming an 'ex-smoker'. This model has been used to explain differential narratives of quitting smoking amongst men and women (Worrell, Maguire & Collins, 2003).

Related to the concept of the 'addict identity' is the idea of the 'addictive personality' from social psychology (Eysenck, 1997). This posits that people who have a tendency to be addicted tend to have a similar personality type, primarily high on the dimension of psychoticism. It has further been suggested that this personality type is the result of biochemical factors, in particular excessive dopamine functioning in these individuals (Eysenck, 1997). The concept of the 'addictive personality' as an explanatory factor for addictive behaviour has flourished particularly in the States (Williams, 1996). Claiming to have an 'addictive personality' has become the way of explaining all types of habitual

behaviour, not necessarily related to substance abuse, such as excessive exercising. A key part of this discourse is the idea that even if one addiction is overcome, then another one will often be taken up as a substitute, as the basis for addictive behaviour is intrinsic at some personality or bio-behavioural level. The 'intrinsic' nature of addictions is clearly linked to recent genetic explanations, as explored in Chapter Two.

However, many researchers have challenged whether an 'addictive personality' really exists (Kerr, 1996; Rozin & Stoess, 1993). For example, Lavelle and Hammersley argue that the strong association between psychoticism/low conscientiousness and substance use may be more to do with the delinquent behaviour normative at certain life stages or in certain social groups rather than a permanent personality type (Lavelle & Hammersley, 1993). Within smoking research, the link between psychoticism and smoking in particular is quite weak or non-existent (Lavelle & Hammersley, 1993). The association is stronger with neuroticism, although as anxiety rates tend to be lower in ex-smokers rather than smokers, this raises the question of whether smoking itself (and the constant withdrawal from nicotine) is stressful and therefore leads to higher neuroticism scores (West & Hajek, 1997).

The interest in this thesis is, however, not whether there is evidence that smoking is caused by an 'addictive personality' but rather what use people make of such concepts as 'addiction', 'addictive personalities' and 'addicts' in relation to smoking. As discussed in Section Two, these terms have been highly contested between tobacco companies and smoking cessation campaigners as the words can carry very different connotations of dangerousness, pleasure-seeking and harmlessness. The words are not morally neutral. Hammersley and Reid (2002) argue that 'addiction' as the primary explanation of substance use is a myth that is socially and culturally functional. It provides a 'simple' (though in their view 'simplistic') account of substance use,

defining it as highly dangerous and therefore diminishing the responsibility of the addict for their behaviour. In line with Crawford's work on the function of 'health consciousness', Hammersley and Reid argue that that cultural function of the 'addiction' myth is primarily as an illustration of how not to behave. Being an 'addict' or 'addicted' transgresses boundaries of health, personal responsibility and self-control. 'Good' individuals can show their mastery of these values by not being an addict, or at least showing their control of substance use by adhering to socially defined in-group norms. 'Addicts', on the other hand, have a morally unacceptable identity, although as part of the 'myth' is that substance use is uncontrollable, they have legitimate claims for 'treatment'.

Hammersley and Reid (2002) argue that legal drugs, such as tobacco, are considered outside the parameters of the 'addiction myth'. But it is far from clear that this is the case. As Chapter Two showed, medical addiction is now the dominant discourse from within the research and clinical community which has campaigned to have smoking nicotine accepted as equivalent to using 'hard drugs' (RCP, 2000). Furthermore, as discussed in Chapter Two, the notions of addiction themselves are contested within society, from within research and health promotion (RCP, 2000) and in the wider societal context because they carry very different connotations. Classifying smoking as a medical addiction similar to heroin or cocaine addiction, for example, might connect it with other discourses surrounding illegal drug use, such as morality, blame and stigmatisation (Rosin, 1999). On the other hand, classifying smoking as a mild addiction similar to an addiction to sex or chocolate might invoke associations with pleasure, hedonism and harmlessness. Internal documents from tobacco companies show their motivation to preserve a 'harmless' classification of smoking addiction (RCP, 2000).

It is pertinent, therefore, to consider how smokers and non-smokers from different SES backgrounds understand addiction and dependence in the context of studying the social identity of being a smoker. It is also interesting to explore how notions of addiction and dependence might link smokers at an identity level to other discourses concerning morality, blame and stigmatisation, as Rosin (1999) might suggest. This thesis therefore investigates concepts of addiction and dependence in two ways. Firstly, the use of addiction discourses within the narratives of participants from different SES groups is explored, paying attention to differences in their salience, language, and the symbolic beliefs surrounding them. Secondly, if addiction discourses are indeed salient, they will be reflected in the statements used for the Q-methodology. This gives the opportunity to understand how discourses of dependence and addiction might be related holistically to other aspects of smoking identities for lower and higher SES participants.

3.5 Smoking and stigmatised identities

Both the theories of Crawford and of Hammersley and Reid are essentially theories of stigmatisation, in that they argue that those who fall outside societal values of being healthy and non-addicted are stigmatised by society and held up as exemplars of how not to behave. In particular, Crawford has taken this further, arguing that we project 'unhealthiness' onto other, already stigmatised, groups of people such as gay people in the case of HIV and AIDS, thus compounding their stigmatisation (Crawford, 1994). The issue for this thesis is to consider whether smokers and their smoking identities might be similarly stigmatised and how this is perceived and coped with by smokers and non-smokers from different SES groups.

Little social psychological research has paid attention to the issue of the stigmatisation of smokers in England, which is perhaps surprising considering that smokers' development into a minority group, in the population as a whole, is well-documented in

cultural studies (Hilton, 2000) as well as epidemiology (e.g. Lader & Meltzer, 2004). Minority status is often, though not always, stigmatised. Stigma is defined by Goffman (1963) as a mark of social disgrace which tends to result in a 'spoiled identity'. This can have a social or group aspect. As Crocker, Major and Steele (1998, p 504) explain, 'a person who is stigmatised is a person whose social identity or membership in some social category calls into question his or her full humanity- the person is devalued, spoiled or flawed in the eyes of others'. Recent theorisation of stigma has emphasised the social and cultural nature of the construction of stigma; what may be a stigmatising characteristic in one era may not be in another (Dovido, Major & Crocker, 2000). Some characteristics, such as facial disability appear to be stigmatised universally, whereas others, such as weight and smoking, are devalued only at certain points in time and in certain cultures. Stigma has, therefore, a contextual and dynamic nature as the valuation of different social identities fluctuates and changes.

There are several theories of the 'dimensions' of stigma; in other words, what determines which characteristics will be stigmatised. Goffman (1963) divides stigmas into three types: 'abominations of the body' (e.g. disability), 'blemishes of individual character' (e.g. addictions) and 'tribal identity' (e.g. race, religion). Smoking would appear most obviously to be a 'blemish of individual character'. It might also be the case, given a potential association with disadvantaged groups, that it constitutes a tribal identity. Jones and colleagues identify six dimensions of stigma; 'concealability' (to what extent the stigmatising characteristic is visible), 'the course of the mark' (how it progresses over time), 'disruptiveness' (the extent to which it disrupts social interaction), 'aesthetics' (the subjective evaluation of the aesthetic dimension of the characteristic), 'origin' (from where the characteristic originates) and 'peril' (the perceived danger which the stigmatising characteristic presents to others) (Jones, Farina, Hastorf, Markus, Miller & Scott, 1984).

Crocker et al. (1998) argue that in fact the two most important dimensions are 'visibility', as this determines how both the stigmatised (known as the 'target') and the stigmatizer (known as the 'perceiver') react to each other and 'controllability', as this determines the extent to which people are blamed for the stigma as well as their attempts to control or eliminate it. This emphasis on 'control' again fits theoretically with both Crawford's thesis and that of Hammersley and Reid when they argue that Western industrial societies value self-control highly. Those who do not exhibit it, for example, through practicing 'unsafe sex' or being 'addicts' are stigmatised. Conversely those who do control their stigmatising characteristics, or do not possess them in the first place, are socially rewarded. It is interesting to consider these dimensions in respect of smoking identities. Initially it might appear that smoking does not score particularly highly in terms of visibility (smokers do not smoke all the time and there may be considerable concealment). In terms of controllability, however, it has particular resonance as a behaviour which can be stopped through quitting. Therefore, those who do not quit may attract the type of blame that Crocker *et al.* suggest.

Stangor and Crandall (2000) argue that the blame which stigmatised groups attract is a function of the 'peril' which they are perceived to represent. They posit that all stigmas are based on an essential functional motivation to 'avoid threat'. This might be to avoid a realistic and tangible threat, such as to one's health or survival or a symbolic threat to one's world view, such as to moral values. They argue that the perception of this threat is often exaggerated (e.g. Gibson, 1979) but, more than this, it is given social validation through both interpersonal interaction and the knowledge of socially held consensual representations of the stigmatised group that establish what is 'normative'. It is unclear in what ways smokers might be seen, or see themselves, as constituting a 'peril'. Given the increasing attention on the issue of passive smoking it may be that smokers are seen as a threat to actual health. Alternatively (or additionally) they may threaten moral

values such as the responsibility to be healthy, as Crawford's thesis might suggest. It is these understandings that will be explored in this thesis.

In terms of specific research into the stigmatisation of smokers, attitudinal research in the US has suggested that the social stigmatisation of smokers is widespread amongst smokers and non-smokers (Goldstein, 1991, Roisin, 1999). However, it is not clear that such strong or pervasive social stigmatisation exists in the social context of England. The most recent 'Smoking-related behaviour and attitudes' survey shows that 60% of non-smokers report that they would mind if people smoked near them, 50% of ex-smokers and 66% of never smokers (Lader & Meltzer, 2004). The most common reasons for this were 'unpleasant smell (61%), 'bad for my health' (45%) and 'affects breathing' (23%). Looking at qualitative research in this area, a recent study with UK lung cancer patients shows that they feel particularly stigmatised because of the strong association with smoking and many patients conceal their disease as a consequence of fearing blame (Chapple, Ziebland & McPherson, 2004). Another recent study into smoking in the Pakistani and Bangladeshi communities in the UK shows the cultural context of stigma; amongst males smoking is widely accepted, whereas amongst females it is associated with stigma, shame and often concealed (Bush, White, Kai, Rankin & Bhopal, 2003). Parry, Thomson & Fowkes (2001; 2002) also found that one of the most prominent themes when interviewing older smokers with arterial disease was the social change of smoking from a socially acceptable behaviour of their youth to an unacceptable one, which often attracted the disapproval of others. However, little qualitative or quantitative research has considered social disapproval or stigmatisation in the wider population, amongst smokers and non-smokers, as well as across class groups, a gap which this thesis aims to rectify.

It must be remembered that from a smoking cessation perspective, stigmatisation may not necessarily be viewed as a bad thing. For example, Kim and Shanahan (2003) show that in the US, the states with the most unfavourable 'smoking climate' in which smoking is socially rejected as a deviant behaviour have lower smoking rates, even after controlling for state tobacco measures. This suggests that public norms of acceptability may have a significant impact on encouraging quitters. They also found that on an individual level, smokers who experienced unfavourable public sentiment were more willing to quit than those who had not. It may be, therefore, that social disapproval or stigmatisation has positive consequences for some individuals in terms of motivating them to quit.

On the other hand, the consequences of further stigmatising already stigmatised groups, who may or may not have the tools for cessation, is not known. The group increasingly identified within research as of concern to government, policy makers and health professionals are 'disadvantaged smokers'. It seems theoretically plausible that their identification as 'smokers', if indeed this is stigmatised, is compounded by their already stigmatised status as 'poor' with its attendant connotations of laziness or lack of forward thinking (e.g. Furnham & Gunter, 1984; Ryan, 1971). Indeed, Petersen and Lupton (1996; Lupton, 1995) in their critique of the 'New Public Health Paradigm' have argued that this tendency to target certain groups within health promotion, such as the poor, highlights them as irresponsible. This in turn leads to them being blamed for their predicament by society at large. It is not clear whether lay people, smokers or non-smokers or from different SES groups have noticed this phenomenon of the 'poor smoker'.

The ways in which smokers from different socio-economic groups might cope with stigmatisation is also considered here. It used to be thought that stigmatisation

necessarily had consequences in terms of poor self-esteem (e.g. Cartwright, 1950; Erikson, 1956). Recently, however, it has been argued that stigmatised groups bring a variety of creative social responses or coping mechanisms into play (Miller & Major, 2000). Facing stigmatisation has several potentially damaging consequences; stigmatised individuals may be the target of discrimination and prejudice, they may be aware that others do not value them (which may lead them to devalue themselves) and they may face social uncertainty or rejection in their interactions with others, all of which lead to stress (Miller & Major, 2000). They may also face indirect negative outcomes such as limitation to resources such as housing, jobs and healthcare which also deplete their adaptive abilities.

Some of the coping mechanisms available in the face of stigmatisation have already been considered above in Section 3.2 concerning SIT. It was noted that stigmatised groups may leave the group itself, use 'exemplars' which counteract their stereotypes, find new dimensions on which they compare favourably, challenge directly the negative derogation or even accept it. Another strategy for the stigmatised is to simply group together so that their stigma is less important. It was also noted that SIT has not been able to predict which of these coping mechanisms different out-groups or stigmatised groups will employ. However, it seems plausible that these will differ depending on the other social identities of the stigmatised group. For example, it might be expected that smokers drawn from lower SES groups might have more limited resources for coping with the stress of stigmatisation, given their life circumstances and already stigmatised status as poor (e.g. Allison, 1998). This thesis will also consider, therefore, how the responses to any stigmatisation of smoking identities might differ in terms of socio-economic group.

3.6 Aims of this thesis

The aim of this thesis is to explore the social meanings and identities of smokers in England amongst smokers and non-smokers from higher and lower SES groups. As discussed in Section 3.2, smoking can be considered a social identity, or group membership, for smokers (Echebarria-Echabe, Fernandez-Guede & Gonzalez-Castro, 1994). In contrast to smoking amongst teenagers, little research has delineated the images and identities of adult smokers, particularly amongst participants from different socio-economic groups. This thesis considers, therefore, whether the notion of identity in relation to smoking is meaningful for lay people. It goes on to consider which discourses are drawn upon by lay people in the creation of identities in relation to smoking. For example, Chamberlain and O'Neill (1998) prompted their participants for health-related information (as this was the focus of their study). However, it is not clear that 'health' will be a key meaning of smoking for participants here. A conceptual map task is used prior to the interview (Study 1) to tap the key discourses that emerge spontaneously from participants themselves.

This thesis also examines the purpose of the identity creation around smoking, particularly in relation to the existing social position of the participants. Crawford (1985) argues that 'unhealthy' behaviour is projected onto already stigmatised out-groups groups, such as gay people and foreigners in the case of HIV/AIDS. Little or no evidence currently exists about which social groups lay people associate with 'being a smoker'. As discussed previously, 'being a smoker' is considered a sign of Western prosperity in China (Jarvis and Wardle, 1999). This is unlikely to be the case in England, where the primary sentiment is anti-smoking (Jarvis and Wardle, 1999). This thesis considers, therefore, whether lay people themselves associate smoking with social disadvantage. It also considers how discourses of stigmatisation, blame and lack of

control might be drawn on to maintain existing social positions, as Crawford's thesis suggests.

This thesis also considers if, and how, the concept of 'addiction' is drawn on by participants in relation to being a smoker. As discussed in this literature review, the notion of 'addiction' itself, and whether smoking constitutes one, has been hotly contested (RCP, 2000). This thesis looks therefore at how smoking and smokers are understood in relation to other drug use. As Hammersley and Reid (2002) point out, loss of control is at the heart of the 'addict identity'. Perceptions of self-efficacy and control do tend to differ between SES groups in relation to smoking (Chamberlain & O'Neill, 1998). It may be the case, therefore, that smokers from lower and higher SES groups will construct their understanding of addiction in relation to smoking differently.

Finally, the social identity and meaning surrounding 'being a smoker' will be considered in the light of the stigmatisation literature (e.g. Jones *et al.*, 1984; Stangor and Crandall, 2000). Given the prevailing anti-smoking sentiment identified by Jarvis and Wardle (1998), it seems plausible that smokers may be stigmatised. Little research has specifically considered this, particularly in relation to disadvantaged groups who are already stigmatised on the basis of their poverty (Furnham and Gunther, 1984). This thesis therefore considers whether 'being a smoker' meets the criteria of stigma and how these understandings might differ as a result of being differently positioned on the social hierarchy.

3.7 Research questions

The overall research question for this thesis is:

What are the social meanings and identities of 'being a smoker' in England? How do these relate to lower and higher socio-economic status?

Sub-questions prompted by the theoretical literature are:

1. How is social identity conceptualised in relation to smoking in different SES groups? How does this function to sustain or challenge the social norms of smoking in these groups?
2. What discourses emerge around 'being a smoker?' in different SES groups? How are alternative discourses constructed in relation to dominant discourses such as 'health' and 'addiction'?
3. What are the emotions, values and judgements attached to 'being a smoker'? In particular, is 'being a smoker' considered a stigmatised identity? How does this play out in different SES groups?

CHAPTER FOUR:

METHODS

4.1 A mixed methodological approach

The overall aim of this thesis is to examine, and where appropriate, compare the creation of social identities, and the meaning-systems on which they draw, in relation to smoking in lower and higher SES groups in England. A mixed methodological approach (incorporating both qualitative and quantitative elements) is used. This consists of two main studies. The first is a semi-structured interview study (Study 1), sampling both smokers and non-smokers (n=40). This qualitative stage is intended to provide inductive accounts of smokers' (and non-smokers') images and identities. This is done through the use of a conceptual map, tapping 'first thoughts' on the topic, before a narrative-based semi-structured interview. The second study (Study 2) consists of a 'Q' methodology study, with a sample of smokers (n=64). This focuses on smokers' identities in particular. Q methodology is a form of pattern analysis that combines qualitative and quantitative aspects to develop a 'taxonomy' of accounts about an issue (Stainton-Rodgers 1991; Stenner, Dancey & Watts, 2000). In this thesis, it is used to clarify and separate smokers' identities into statistically discrete factors.

The two studies are envisaged as complementary. Items for the Q sort are primarily drawn from the interview data from the first study. This thesis thus uses triangulation through multiple methods to study the research questions, which has the potential to increase the validity of such research (Dockrell & Joffe, 1992; Yardley, 2000).

4.2 Theoretical rationale for methodology

4.2.1 *Conceptual mapping prior to interview study*

Conceptual mapping, also known as ‘cognitive mapping’ is a standardized research method used both in the social sciences (Axelrod, 1976) and market research (Krueger 1994). It has been used in health psychology, for example, to explore different illness perceptions and representations of lupus amongst groups differing in age, severity and length of illness (Wiginton, 1999). The task involves filling in a grid on a sheet of paper, putting a different aspect or dimension of the given topic in each box. The map can be filled using both words and pictures that are associated with each dimension. After completing the maps, they are used as tools for discussion for participants.

The ‘conceptual map’ technique has been used to look at the social identities of adolescent smokers (Lloyd & Lucas, 1998). Their grids comprise six boxes, with an ‘image of a smoker’ in each box. Teenagers in their study filled in the grids with the researcher, which were subsequently used as the basis of group discussion. Lloyd and Lucas used the contents of the grid and the discussions to locate the ‘dimensions’ or factors that comprised the images of smokers for adolescents. These dimensions include a) ‘intrapersonal’, such as character weakness, personal control and intelligence b) ‘interpersonal’ (the social group to which the person belongs), such as social status, sophistication, sociability or social inclusion/exclusion; and finally c) ‘physical attributes’, namely physical attractiveness.

In the first study of this thesis, participants were asked to create a similar conceptual map containing images of smokers and non-smokers prior to the main interview. Its main purpose was to elicit the spontaneous first thoughts of participants about the phenomenon in hand. First thoughts or free associations reflect the ‘contents and representational systems of human minds’ (Benthin, Slovic, Moran, Severson, Hertz et

al., 1995, pp.144). In line with a psychodynamic perspective, the first thoughts of participants are assumed to reflect their most salient, stored associations. Such thoughts may represent freer, symbolic and less rational material that may or may not be held at a conscious level (Joffe & Lee, 2003). The conceptual map, produced alone by the participant, is then the subject of dialogue during the interview. This allows the researcher to clarify details, but also to work initially with the agenda that the participant has provided, rather than impose their own meaning structure. It also allows the researcher to look at how the automatic, spontaneous material (which is more likely to be simple and perhaps stereotypical) is then explained by the participant. Both types of material will together reflect the conceptualizations or representations of the phenomenon (Joffe & Lee, 2003). In this instance, it was thought that the conceptual map would provide clues to the most salient, but also perhaps less conscious, aspects of smoking identities for participants.

There were also strong reasons for not wishing to simply launch immediately into the question and answer interview format with the topic of smoking. It has been argued such direct questions ('what?' 'where?' 'why?') tend to produce intellectual rationalizations or justifications on the part of interviewees (Holloway & Jefferson, 1997). Research from the U.S. has indicated that smoking is a socially stigmatised activity (Goldstein, 1991). It is likely, therefore, that some smokers might feel they have to justify why they smoke. Similarly, non-smokers might feel that they have to justify their attitudes towards smokers. It was felt that the conceptual map would provide a good introductory, 'scene-setting' task, without provoking defensiveness or the need to 'account' for oneself.

The conceptual map also provided an opportunity to capture the management of self-identity in relation to perceived societal images. One key area of interest in this thesis is

to consider how socially held images of smokers (as ‘the Other’ or ‘out-group’/‘in-group’) are psychologically managed by smokers and non-smokers themselves. Having completed their individual map, therefore, participants were asked ‘are there any images here that you identify with yourself?’

At the start of the research process, different methods for producing first thoughts and associations were compared through piloting. The original intention was to use pictures of smokers as prompts. However, on testing, it was revealed that participants were often distracted by other elements in the photos (such as what the people were wearing) rather than focusing on the smoking behaviour portrayed. The conceptual map, as used by Lloyd and Lucas was tested simultaneously. It was felt to be much better at generating the desired spontaneous material. However, the instructions and design were slightly modified. The grid was reduced from six to four boxes as no participants used more than four boxes. With a larger grid, participants reported feeling under pressure to produce lots of images and worried that they were not able to do the task properly. Using four boxes produced richer, more detailed images. The instructions were also modified in line with feedback concerning their clarity. The conceptual map used in this study is found in Appendix A: 1.

4.2.2 *Semi-structured interview study*

Interviewing is usually seen, alongside focus groups, as *the* corner-stone methodology of qualitative research. The vast number of papers on smoking attitudes and beliefs are positivist in theory and utilise questionnaires and occasionally structured interviews as methods. However, of late, increasing numbers of papers on smoking have been published based on qualitative interview methodologies (e.g. Amos, Wiltshire, Bostock, Haw & McNeill, 2004, Bancroft et al., 2003a and 2003b; Chamberlain & O’Neill, 1998; Graham, 1993a; Haslam, Draper, & Goyder, 1997; Parry, Thomson & Fowkes, 2001

and 2002; Thompson, Thompson, Thompson, Fredrickson & Bishop, 2003). Graham's work, detailed in Chapter Three, has received much attention. Their findings have been seen as highly effective in providing a fresh conceptual leap forward in what was a mature research field in danger of stagnation. This chapter offers a rationale for using a broadly semi-structured interview format, which aims to capture narrative data alongside abstract opinions.

Interviews have always been an integral part of the quantitative methodological canon, but only at the pilot stage of an investigation, so the results typically go unpublished. As a pilot method, they are used to form hypotheses to be tested in a quantitative survey, to elicit the range and nature of items that should be included in a questionnaire, and to test question wording and measurement scales before implementation (Fontana & Frey, 1998). However, in line with existing qualitative research, the semi-structured interview is used differently in this thesis. Rather than being a useful, but preliminary tool to be used before the 'real' data collection begins, it is used as a method in its own right. This represents a re-prioritisation of the subject's, or 'interviewee's' own words, definitions and arguments rather than limiting responses to options provided by the researcher on a questionnaire or scale of their devising (Silverman, 1993).

One key advantage of using semi-structured interviews is that they let the 'voice' of the subject be heard (Oakley, 1981). In both questionnaires and structured interviews, the researcher pre-defines all aspects of the phenomenon under investigation and limits the possible responses that the subject may want to give. Open-ended questions, on the other hand, allow the interviewee to conceptualise the phenomenon themselves and use their own words to describe their conceptualisations. This 'open-answer' approach can usefully reframe a research question. The work of Chamberlain and O'Neill, for example, has examined the influence of 'health beliefs' on smoking (Chamberlain &

O'Neill, 1998). Scales that measure health beliefs typically assume that 'health' has one meaning (e.g. Lau, 1986). However, Chamberlain and O'Neill's analysis of semi-structured interviews showed that lower SES groups define 'health' in functional terms as 'not being ill', whereas higher SES groups conceptualise 'health' as an ideal to aspire to, a sense of 'well-being'. These differential understandings of 'health' affected the way in which they conceptualised their smoking in relation to it. A similar, open-ended interview structure is used here to capture participants' accounts using their own language and definitions.

Given that pre-defined, standardised questions make an assumption of homogeneity of understanding on the part of the subjects, one solution might be to locate and remove definitional differences during the pilot phase of testing (e.g. by defining the term 'health' or 'smokers' for subjects). However, it is argued here that such differences are not 'problems' to be solved, but discoveries in their own right. It cannot be argued that a phenomenon has been fully investigated if aspects of it that do not fit the researcher's definition are removed. As such, semi-structured interviews can be argued to have high validity.

Some qualitative researchers have gone further in their claims for this type of interview, arguing that 'giving voice' to participants has an emancipatory function (Habermas, in Silverman, 1993 pp.173; Oakley, 1981). It is argued that the attitudes and beliefs of dis-empowered groups *framed in their own words* are not usually heard by governments, elites, nor as Oakley argues, by patriarchal male scientists. However, these claims can be challenged. All good research, whether qualitative or quantitative, can have an emancipatory function. As was detailed in Chapter One, the statistical analyses of the prevalence of smoking in the general population have highlighted the differential class rates of smoking. Without such research, the differential suffering of disadvantaged

smokers would go un-quantified and ignored. Secondly, we must be careful not to overstate the extent to which semi-structured interviews ‘liberate’ the interviewee from the confines of the researcher’s assumptions. Such interviews arguably allow the interviewee more room to define and explain their attitudes and beliefs, but they are not free-for-all unstructured conversations. A pre-set topic guide is followed which aims to cover all research questions systematically, so that cross-individual and cross-group comparisons are possible. What semi-structured methods do offer is a balance between exploring the pre-theorised questions of the researcher and being open to the possibility that new data may emerge from the interviewee’s more spontaneous responses.

It is also contended that semi-structured interviews are a good tool for exploring inconsistencies in people’s creation of smoking identities. The work of Billig is illuminating in this respect (Billig, 1987). Billig argues that questionnaires make too many assumptions about the rationality and consistency of people’s attitudes. Drawing on the metaphor of the rhetorical scholar, he draws a distinction between the cognitive processes of ‘internal deliberation’, inner thought which resembles an argument in which we take both sides ourselves and ‘external advocacy’, where we have to justify ourselves to others and which we perceive demands a consistent and logical response. He argues questionnaires tap ‘external advocacy’ of attitudes, but not the ‘inner deliberation’ which often remains changeable or unresolved. Surveys draw a veil over these inconsistencies and so the attitudinal measures they produce are not good predictors of health behaviour.

Billig’s point that questionnaires do not cope well with inconsistency in subjects’ thoughts is well made. The problem is indeed inherent in questionnaire design because the process of reliability testing is designed to remove logical inconsistencies and incompatibilities between items and consequently their potential to detect illogical or

inconsistent attitudes. No-where is this problem more pertinent than in the field of smoking attitudes, beliefs and understandings where smokers often hold highly ambivalent attitudes and emotions towards their behaviour, both detesting and enjoying their habit, wanting to give it up and wanting to go on smoking. Indeed, it has been argued smoking is the ultimate paradoxical pleasure, as it is both known to be risky, yet smokers find it exciting and pleasurable (Klein, 1993). Semi-structured interviews offer a potential method through which to access and systematise these paradoxical understandings.

However, the semi-structured interview technique is not without its critics. As mentioned in the previous section on the conceptual map, Holloway and Jefferson have criticized semi-structured interview questions ('what', 'when', 'why'?) for encouraging intellectualizations and generalized statements (Holloway & Jefferson, 1997). In other words, they may still result in tapping the 'external advocacy' of which Billig speaks. Their solution to this weakness is to conduct interviews which probe for narrative, rather than abstract, data. There has been considerable emphasis on narrative as a primary form of human understanding from within constructivist epistemologies (Henwood and Pidgeon 1993). Narratives are argued to possess an innate structure which all humans can use, both internally, to structure their own experience, and externally, to share the meaning of these experience with others. Narrative is thus argued to be a 'meta-code', a 'universal competence' (Ricoeur 1984). However, narrative or biographic interviews can often be very lengthy (2 to 16 hours) (Schuetze, 1977). Biographical narratives are also often case-specific (Flick 1997). This makes the type of (non-statistical) cross-comparison between groups, as required in this thesis, difficult to undertake.

It was decided, therefore, to use an ‘episodic’ interview format (Flick, 1997). This takes the semi-structured format and adapts it to include narrative data in the form of ‘episodes’ from individuals’ lives (Flick 1997). This has the advantage of allowing one to obtain abstract knowledge and opinions (as with a traditional semi-structured interview) as well as obtaining valuable narrative data linked to people’s concrete circumstances and experiences. In this study, an initial topic guide was produced covering pre-theorized questions, as with all semi-structured interviews (Appendix A:2). Questions were also asked about smoking/smokers in the main ‘domains’ of life, namely work, leisure and family/relationships. There was a deliberate attempt to keep questions as open as possible. It aimed to cover all topics in the interview, but not necessarily in a particular order. Issues, that emerged as part of the conceptual map, were considered first as these were clearly salient for participants. Participants were not asked specifically about their ‘identity’ as smokers and non-smokers, in line with the theoretical position that identities are created in everyday behaviour and experience. Participants were instructed at the outset to tell stories or give examples/instances in response to each question. They were prompted on this throughout the interview.

4.2.3 *Q-methodology study*

Since its development by William Stephenson (Stephenson, 1953), Q methodology has been applied to many topics and issues, such as ‘maturity’ (Stenner & Marshall, 1999) and ‘jealousy’ (Stenner & Stainton-Rodgers, 1998). Q methodology has been used to examine social identity constructions, for example, lesbian identities (Kitzinger & Stainton-Rodgers, 1985). Of late, there has been a resurgence of interest in using Q methodology studies in psychology in general (Watts & Stenner, 2005) and in the area of health and illness in particular (Cross, 2005; Stenner, Dancey & Watts, 2000; Risdon & Eccleston, 2003). Only one Q-methodological study on smokers’ understandings of

their smoking behaviour has been published (Collins, Maguire & O'Dell, 2002). This found four discrete representations of smoking behaviour; smoking as a social tool, the dual identity smoker, reactionary smoking and smoking as a social event. Their study's participants came from a variety of ethnic backgrounds; however their SES is not specified. To the best of the author's knowledge, no Q-methodological study has examined smoking identities with participants specifically from diverse socio-economic backgrounds. This section, therefore, provides a rationale for undertaking such a study within the context of this thesis.

The overall aim of a Q sort is to clarify and separate accounts of a topic. In other words, it identifies the numerous socially shared 'positions' or 'voices' on an issue that individuals in a given cultural community might hold. In a Q-sort, participants are given a set of statements and asked to sort them into a pattern which reflects their thinking about a topic. Typically this is along a continuum of preference, such as agree/disagree or important/not important. Pattern analysis (correlational) is used to show the relationship between these statements of opinion, thus creating a 'view-point' on the issue at hand. Even with only 30 statements, more than 11,000 potential sorts (or viewpoints) are possible (Brown 1980). However, by factor analyzing these sorts, it is possible to show whether the Q-sorts have been similarly arranged by different individuals at a greater level than chance. In other words, factor analysis will reveal the existence of a limited number of socially shared points of view. Similar Q-sorts are merged to create a (weighted) average Q-sort, known as an 'exemplar', which is literally exemplary of that point of view.

A theoretical contrast has been drawn between traditional 'R' and 'Q' methodology (Stephenson 1953; Brown 1980). 'R' methodology is traditional pattern analysis such as Pearson's product moment correlations or Spearman's factor analysis. It aims to

measure concepts (such as personality traits) in a population of individuals. These concepts are pre-defined by the researcher who aims to create one 'valid' measure of the concept. Scores on the measures are aggregated across the sample and assumed to have a normal distribution. It is a hypothetico-deductive method, in other words it statistically tests prior hypotheses (a 'top-down' approach).

'Q' methodology, on the other hand, aims to measure a population of ideas, rather than individuals. It is primarily an inductive ground-up methodology. As Brown states 'the thrust of Q methodology is not one of predicting what a person will say, but in getting him to say it in the first place (i.e. by representing it as a Q-sort) in the hopes that we may be able to discover something about what he means when he says what he does' (Brown, 1980, pp.46). Like semi-structured interviews, therefore, the possibility exists of generating new discoveries and theories from the data itself.

Another parallel with the semi-structured interview method is the emphasis on the primacy of the participant's own 'voice' (Brown 1980). Brown classifies Q-sort as a key method for the study of 'operant subjectivity'. The behaviour, in the form of opinions or statement, is 'subjective' because it is simply the person's viewpoint and it is 'operant' because it exists naturally within a particular setting. Q-methodology is certainly different than questionnaire design in several key ways. There are no 'right' or 'wrong' answers, and participants are free to place seemingly 'inconsistent' items together if they so feel. Secondly, each participant may interpret the meaning of the statements differently. In questionnaire scales (using 'R' methodology), it is assumed that the scale measures a pre-defined construct about which there is homogeneity of understanding.

As with the semi-structured interview, many have claimed that Q-methodology 'liberates' the subject from the researcher's prior assumptions. As was argued in the last

section, this is a little over-stated. In a Q-sort, the researcher clearly influences and delineates the research issue in question by choosing the statements to be sorted. Furthermore, sitting at home sorting attitudinal statements is not a 'naturalistic' setting in which to express opinions, just as sitting opposite a researcher asking questions based on a topic guide is not the same as discussing an issue with friends over the dinner table. However, like semi-structured interviews, Q-methodology allows considerable freedom on the part of participants to express how they stand in relation to a topic. This particularly emerges in the final stage of the sort, where participants are asked to comment on those items which were significant to them or about which they feel strongly.

Another advantage of the Q-sort is the emphasis on obtaining a holistic 'idiographic' point of view. Unlike in 'nomothetic' questionnaire design, where items are de-contextualized and are primarily analyzed separately or as bi-variates, all items in a Q-sort are understood to be inter-related and integral to the whole. This is particularly important in the context of investigating smoking identities, which are understood in this thesis to be both contextualized and integrated. In most research into identity and smoking (where identity is conceptualized as 'self-identity' rather than 'social'), 'self-identity' or 'self-concept' is measured on specific scales only concerned with that aspect of smoking (e.g. Snow & Bruce, 2003). However, it has been the contention in Chapter Three that smoking identities are integrated, indeed constructed, within the behaviours and practices of daily life. A Q-sort design, in which the unit of analysis is the whole Q-sort, not individual items, allows this integrated relationship between all aspects of smoking and smoking identities to be preserved.

Q-sorts, like semi-structured interviews, can also cope with complexity. Brown, like Billig, argues that methodology has to allow for the internal logic of the person to

emerge. The sorting procedure of the Q, and the subsequent comments that are made, conform to what Brown describes as the 'dynamic principle' (Brown, 1980, pp.44). In other words, there is space, within the research method, for people's psychological reactions to the task and the issue at hand to be exposed. As argued in the previous section, this is particularly important in the context of investigating a phenomenon such as smoking, about which many paradoxes and complexities exist.

Finally, unlike in interviews where the demographic groups are pre-specified, the grouping of the participants loading onto a particular Q-sort factor is free to vary. It has been argued that in R-methodology, the categories which are entered into the analysis (e.g. SES or gender) tend to emerge in the results. In other words, if one looks for SES differences, one will find them (Ernest, 2001). This argument could be made about the interview methodology used here, although every effort is made to pay attention to similarities between SES groups as well as their differences. In the Q-sort, participants who load onto a particular factor can hold similar beliefs, but come from very different demographic groups. By choosing a sample which varies specifically by socio-economic status, trends in grouping can be observed (Ernest, 2001). It must be stressed, however, that any association between a Factor and the demographic characteristics of the participants that load onto it is not tested at a statistical level by a Q-sort.

Although there were many good theoretical reasons for undertaking a Q-sort of smoking identities, there was one main reason for reservation. This thesis focuses specifically on smoking inequalities between lower and higher SES smokers. The Q sort is a task that requires considerable literacy skills and the ability to follow complex instructions. Poorer educational attainment is associated with lower SES (Baker, 2003). It was thought, therefore, that a Q-sort might prove an exclusive (and excluding) methodology.

However, despite some reservations, it was decided to proceed. Certainly, Q-method is not exceptional in its potential for exclusiveness. The vast majority of research requires high standards of literacy and comprehension, one reason amongst others why students are over-represented in study samples. The solution was to acknowledge this as a potential limitation, and take this into account when designing the Q-sort. The Q sort was made as 'user-friendly' as possible. Items were generated as simple, short sentences, whilst preserving their authenticity. The Q sort instructions were also rewritten numerous times to make them as simple as possible and piloted to test this. A helpline number was also given to participants to use if they found the Q sort difficult.

Turning now to the 'fit' between the interview (Study 1) and the Q-sort (Study 2) it should be clear that they are complementary at a theoretical level. Both emphasise how people themselves understand their smoking. They both allow the subject's voice to be heard. However, the aim of conducting Study 2 was not to replicate Study 1, but rather to develop it. Thus the sample in the Q-sort consisted solely of smokers from different SES backgrounds, rather than a mix of smokers and non-smokers as in the interviews.

This was a pragmatic as well as theoretical decision. It proved difficult to create items for a Q-sort to which both smokers and non-smokers could relate. This is because for the smoker, smoking is something about which they have intimate, experiential and daily knowledge. For the non-smoker, however, smoking is an abstract and perhaps rather distant behaviour. One option would have been to create general statements about smoking that could have been endorsed by either. However, given the emphasis on identity, it made more sense to include self-referencing statements such as 'I feel like to stop smoking would be to lose part of myself' which would only be relevant to a smoker. Hence the Q-sort sample comprised smokers only.

The social setting of the Q-sort was also different than that of the interviews. The interviews were conducted on a face-to-face basis at UCL. However, the Q-sort was conducted by post so that it was completed anonymously by participants at home alone. This decision was partly pragmatic. A reasonably large sample (60+) was desired and for time and safety reasons it was decided not to visit people in their own home. Additionally it was hoped that this difference in setting might provide an opportunity for the articulation of more ‘unsayable’ or less ‘PC’ aspects of smoking identities. During the interviews, several such topics emerged, such as rebelliousness, risk-taking and societal defiance, particularly amongst smokers. It was clear that although happy to raise these issues, smokers also felt some pressure to distance themselves from these topics or they were mentioned very briefly. Consequently they were less represented in the eventual analysis. It was hoped that smokers in the Q-sort study would be free to consider these less dominant aspects of smoking identities without having to account for their views immediately to a researcher.

4.2.4 Quality criterion in qualitative/mixed methodology research

The issue of quality criterion for these methodologies must also be addressed. Validity is delivered in positivist research by reliability (replicability). However, one has to question whether replicability, either of interviews or coding, makes sense from a qualitative perspective. One can certainly never replicate a semi-structured interview in which the interaction between interviewer and interviewee is specifically and purposefully fluid. It is possible to duplicate coding, particularly that undertaken using a text-based computer package, as in this thesis. However, such replication only appears to offer a yardstick of quality if the two codings are relatively similar (by calculating the kappa co-efficient). This can be ensured if one trains the other person to operationalize codes in the same way as the first researcher. However, this does not tell us whether the

original coding is plausible or credible, simply that someone else can learn to duplicate it (Yardley, 2000). Thus reliability coding is not considered theoretically merited in this instance.

Yardley suggests that an alternative criterion to be employed in qualitative research should be 'transparency' (Yardley, 2000). Put simply, this means opening all aspects of the research method, including the underlying theoretical assumptions, up for inspection. This allows other researchers to examine the research, make comparisons with other studies, and to assess the legitimacy of the research claims.

There are several areas in which published interview studies are often found wanting in terms of transparency. One is the way the sample is derived. In positivist research, generalizability is assumed to be generated through random sampling. However, random sampling is not necessary for non-statistical analyses and therefore not appropriate here. That does not mean, however, that the construction of the sample is of no interest. One wants to consider the parameters of the sample to assess its 'comparability' with other research and the 'typicality' of the phenomenon (Denzin & Lincoln, 1994). The sampling strategy used here is presented in the next Methods section, with the demographic characteristics of both Q-sort and interview samples being found in Chapter Five for the purposes of such transparency.

Another problem with existing qualitative interview studies is that the topic guide/questions and the codes used are rarely published in papers. This is a source of considerable frustration. Although one cannot replicate an interview study, one may wish to conduct a comparable study and observe differences if they occur. This is a difficult undertaking if no details of the questions/topic guide or coding frame are available. A second reason to encourage the publication of topic guides is that without it, it is hard to assess the spontaneity of interviewee's responses. For example,

Chamberlain and O'Neill's paper on health and smoking identified three discrete thematic factors that show SES group differences: understandings of 'health', efficacy of health behaviours and situational constraints (Chamberlain & O'Neill, 1998). However, because no topic guide is published, it is hard to tell if these reflect the spontaneous concerns of these groups regarding health and smoking, or whether each 'theme' emerged in response to specific questions or prompts about that factor. It would not invalidate their findings if such results were the result of targeted questions, but it does change the conclusions one might want to draw from them. The topic guide and questions used in these interviews are found in Appendix A: 2 for the purposes of this evaluation.

Transparency is less of a problem in published Q-methodology studies. Typically the Q-sort items, the grid and an at least one 'exemplar' Q sort for one of the factors are included in the paper. These items are included in Appendix A (3 & 4) and in the Results section. There are also specific quality criteria for many aspects of Q-methodology. For example, factors with an eigenvalue of less than 1 (meaning that at least one person's sort loaded significantly onto the factor) are typically excluded from analysis, although whether this is the correct criterion is open to debate (Brown, 1980).

In addition to transparency, this thesis also adds quality through the triangulation of methods. Originally 'triangulation' was understood as a way of overcoming the idiosyncrasies and biases inherent in each method, such as the type of social interaction involved or the role of the researcher (Denzin, 1970). It was thought that by combining the methods, a more 'objective' and therefore more valid result would be achieved. This is clearly similar to the positivist (realist) criterion of 'replicability': the phenomenon is measured in multiple ways in order to discover 'the truth'.

'Triangulation' as a quality criterion is understood differently by qualitative researchers (Dockrell & Joffe 1992; Yardley, 2000). Triangulation is not a way of removing the 'bias' of subjectivity, but paying respect to it by accessing different perspectives. For this reason, this thesis contains three different methodologies (conceptual map, semi-structured interviews and a Q-sort) to examine different dimensions of the same phenomenon: 'being a smoker'. It is hoped the resulting research will be more detailed, more complex and thus is more likely to be both credible and plausible as a consequence (Silverman, 1993).

4.3 Methods and procedure

4.3.1 Conceptual map and semi-structured interviews

4.3.1.1 Sampling strategy

There was an *a priori* determination of the sample structure (Flick, 1998). The sampling frame (n=40) was designed to vary in terms of two factors; smoking status (smoker/non-smoker) and socio-economic status (higher SES/lower SES), as illustrated in Table 4.1:

	Higher SES	Lower SES
Non-smokers	10	10
Smokers	10	10

Table 4.1 *A priori* sampling strategy for interview participants

This sampling frame allowed comparisons to be made between different groups on the following theoretical basis:

Socio-economic status: The review in Chapter One outlined the considerable differences in smoking rates amongst different SES/class groups. SES was divided into two categories for the studies in this thesis: higher SES and lower SES, corresponding to the

older manual/non-manual or ABC1/C2DE classification. SES was defined using the new NS-SEC SOC 2000 classification⁶ developed for use in the 2001 Census (Rose & O'Reilly 1998; Rose & Pevalin, 2001). There are eight categories. Lower and higher SES was obtained by a median split. Those who were included in the first four categories (higher (1) and lower (2) managerial and professional occupations, intermediate occupations (3) and small employers and own account workers (4)) were defined as 'higher SES'. Those in the other four categories (lower supervisory and technical occupations (5), semi-routine occupations (6), routine occupations (7) and never worked and long-term unemployed (8)) were defined as 'lower SES'.

Smoking status: Research already reviewed in this thesis has suggested that smokers and non-smokers make differential attributions (Eiser, Sutton & Wober, 1978) and hold different images of adolescent smokers (Lloyd & Lucas 1998). For this reason, the interview sample was divided into two groups: smokers and non-smokers. Smoking status was assessed using questions from the ONS Smoking Surveys (Jarvis, 1997). Smokers were defined as regular smokers who currently smoke more than one a day/ex-smokers who used to smoke more than one a day. Non-smokers were defined as those who do not currently, or have never, smoked more than one a day (Royal College of Physicians, 2000). (*Over the past year, how many cigarettes do you usually smoke a) in a day or b) in a month?*). Ex-smokers were not included in this sample. Although they undoubtedly constitute an interesting group in terms of changing identity, it is hard to

⁶ The questions used to derive the NS-SEC classification were: 'Please tick the one box which best describes how you spend most of your time' (in paid employment/a full-time student/looking after family/retired/sick or disabled/unemployed/other); 'What is the full title of your main job?'; 'Describe what you do in your main job'; 'What is the business of your employer at the place where you work?'; 'Do you work as an employee or are you self-employed?' (employee/self-employed with employees/self-employed without employees); 'How many people work for you/your employer at the place where you work?' (1 to 24/25 or more); 'Do you supervise any other employees on a day to day basis?' (yes/no).

define an 'ex-smoker' (as many only temporarily quit) and it was felt that the dichotomous divide might produce clearer results than a three-way sample.

Other questions from the ONS Smoking surveys are also included to assess age when started (*'how old were you when you started smoking?'*), number of quit attempts (*'how many times have you tried seriously to stop smoking over the past 5 years?'*: never/once/2-4 times/ 5 or more times) and motivation to quit (*'how much do you want to give up smoking altogether?'*: not at all/slightly/moderately/quite strongly/very strongly).

Two additional questions were included to measure dependence, *'what is the longest time you have gone without smoking over the past 5 years, not counting days that you were ill or in hospital?'* (less than 1 day, 1-6 days, 7 days to one month, a month+) and time to first cigarettes *'when do you smoke your first cigarette of the day after waking up?'* (1-30 minutes, 31-60 minutes, 1-2 hours, 2 hours or more) were also included. Smoking in the first half hour of waking is taken to indicate high dependence on nicotine (Royal College of Physicians, 2000).

Gender: Gender is a determinant of smoking behaviour, with more men than women currently smoking (28% of men vs 24% of women) (Lader & Meltzer, 2004). Lloyd and Lucas also found that there were gender differences in the images of smokers amongst adolescents. Females, for example, were more likely to hold negative images of young female smokers than males (Lloyd & Lucas, 1998). Equal numbers of men and women were therefore sampled.

Age: This is a study of adult smoking behaviour. 95% of smokers start smoking before the age of 19 (Jarvis & Wardle, 1999). Smoking behaviour is greatest in the 20-24 age group, whereupon it declines with age. Age is also important because the majority of

smoking related illnesses appear 20-30 years into a smoking career (Royal College of Physicians, 2000). Given that nearly all regular smokers have started by 20 and that smoking-related illnesses appear 20-30 years later, the age range for the study was defined at 20-60 years (*'how old are you?'*). This also allowed for a median split.

Ethnicity: There are considerable differences in smoking rates amongst ethnic groups, particularly for individuals born outside the UK. For example 44% of Bangladeshi, 35% of Black Caribbean and 39% of Irish men smoke compared with 27% in the general population (Department of Health 1999). Only 1% of Bangladeshi women smoke. Although interesting, ethnicity and smoking is not the main focus of this thesis. The sample therefore included only those born in the UK. Participants were asked a check question *'were you born in the UK?'* (yes/no) and *'to which ethnic group do you consider you belong?'*

The demographic questionnaire is contained in Appendix A:5.

4.3.1.2 Participants

Table 4.2 shows a summary of the demographic details of the interview participants.

Variable name	Categories	Non-smokers N=20	Smokers N=20
Gender	Male (n=20)	10 (50%)	10 (50%)
	Female (n=20)	10 (50%)	10 (50%)
Socio-Economic Status	Higher (n=20)	10 (50%)	10 (50%)
	Lower (n=20)	10 (50%)	10 (50%)
Age	20-40 age group (n=20)	10 (50%)	10 (50%)
	40-60 age group (n=20)	10 (50%)	10 (50%)
Children	None	10	14
	1-4 children	10	6
Ethnicity	White	19	15
	Black/asian/other	1	5
Age started smoking	Mean=	n.a.	14.2
No. cigarettes a day	Mean=	n.a.	17
	Less than 10	n.a.	8 (40%)
	10 to 20	n.a.	8 (40%)
	More than 20	n.a.	4 (20%)
No. times tried to stop	Never	n.a.	3 (15%)
	Once	n.a.	5 (25%)
	2-4 times	n.a.	7 (35%)
	5+ times	n.a.	5 (25%)
In past 5 years, not smoked for...	Less than one day	n.a.	4 (20%)
	1-6 days	n.a.	3 (15%)
	7 days-1 month	n.a.	9 (45%)
	More than 1 month	n.a.	4 (20%)
Desire to quit smoking	Not at all	n.a.	3 (15%)
	Slightly/moderately	n.a.	7 (35%)
	Quite/very strongly	n.a.	10 (50%)
First cigarette of the day within...	Less than 30 min	n.a.	8 (40%)
	30 min to 1 hour	n.a.	2 (10%)
	1 to 2 hours	n.a.	3 (15%)
	More than 2 hours	n.a.	7 (35%)

Table 4.2 Demographic characteristics of the interview participants

Table 4.3 below shows the individual details of each participant in terms of their age, gender, occupation, ethnicity, number of children and number smoked per day, plus any other details which were noted. This is followed by a general summary of the interview research sample.

P1	Smoker, HSES	Female, 23, postgraduate student, commuting in from Essex to London, worked part-time, white, no children, smoked 3 a day
P2	Smoker, HSES	Female, 26, postgraduate student, white, no children, smoked 5 a day, 'more on weekends'
P3	Smoker, HSES	Female, 30, marketing manager, white, one child, smoked 5-10 a day
P5	Smoker, HSES	Female, 30, postgraduate student, black, no children, working half year in Africa, smoked 8 a day
P6	Smoker, HSES	Female, 39, artist, black, 'Caribbean background', no children, smoked 5-10 a day
P11	Smoker, HSES	Male, 33, working as database manager in large Central London office, white, no children, smoked 10-15 a day
P13	Smoker, HSES	Male, 54, freelance writer on African politics, 'Black British', one grown-up child who had left home, smoked 13 a day
P18	Smoker, HSES	Male, 32, worked in 'IT' at management level, mid-thirties, white, smoked 25 a day, one child
P37	Smoker, HSES	Male, 43 years old, product manager, living with partner, no children, smoked 20+ a day
P4	Smoker, HSES	Male, 35, political scientist, former business consultant, white, no children, smoked 12 a day
P19	Smoker, LSES	Female, 39, part-time cleaner and single mother to two teenage boys, white, living partially on Working Credits, recruited through Smokers' Clinic, though never attended for treatment, smoked 20 a day
P20	Smoker, LSES	Female, 55 years, two children who had left home, worked as carer for elderly for 25 years, on incapacity benefit due to health problems, recruited through Smokers' Clinic, though never attended for treatment, smoked 30 a day
P 21	Smoker, LSES	Female, 41, Receptionist for office in Camden, no children, 'black British'
P 22	Smoker, LSES	Female, 34, single mum, two children, older primary age, worked as cleaner, now on benefits, white
P 23	Smoker, LSES	Female, 31, worked as secretary in large European bank, white, no children, living in suburbs, smoked 15 a day
P7	Smoker, LSES	Male, 37, working as porter, white, no children, smoked '40' or more a day
P31	Smoker, LSES	Male, 46, odd-job/maintenance in large European bank, white, living in suburbs, smoked 'about 14 a day', no children
P34	Smoker, LSES	Male, 54, worked as a welder and fabricator on the factory floor, owned own house, had three children, smoked 10-20
P35	Smoker, LSES	Male, 40 years old, admin assistant, living with parents, no children, smoked 10 a day
P40	Smoker, LSES	Male, 24, gym receptionist at a gym in Central London, white, no children, '15 on weekends, less in week'
P8	Non-smoker, HSES	Female, 27, 'Japanese/British' heritage, management consultant, no children
P9	Non-Smoker, HSES	Female, 28, working as risk consultant in Central London, living in suburbs, white, no children
P15	Non-Smoker, HSES	Female, 50, worked as teacher (head of department), two primary school-age children, 'one deaf', white
P27	Non-Smoker, HSES	Female, 54, Senior staff nurse, working in large hospital in London, white, two grown-up children
P28	Non-Smoker, HSES	Female, 57, teacher, two grown-up children
P14	Non-Smoker, HSES	Male, 43, worked as senior economist, office-worker, commuting, two children, primary age
P26	Non-Smoker, HSES	Male, 30, working as 'documents manager' in large European bank, white, one child
P29	Non-Smoker, HSES	Male, 52, deputy head-teacher, white, two children, one living

		at home, other at university
P30	Non-Smoker, HSES	Male, 46, two children aged 20 and 18, works as team supervisor for 'support' for transport and gas supplies, white
P32	Non-Smoker, HSES	Male, 55, working as sports administrator, living in shared house, no children
P24	Non-Smoker, LSES	Female, 45, working as catering assistant in kitchen, white living in suburbs, no children
P36	Non-Smoker, LSES	Female, 35, paralegal secretary, three children
P25	Non-Smoker, LSES	Female, 24, working as secretary in large European bank, white, living in suburbs, no children
P38	Non-Smoker, LSES	Female, 49, home-maker (no previous employment mentioned), one child
P39	Non-Smoker, LSES	Female, 23, gym receptionist at a gym in Central London, describes self as 'Black British', no children
P12	Non-Smoker, LSES	Male, 40, security guard, white, no children
P16	Non-Smoker, LSES	Male, 26, working as administrative assistant, no children, white
P17	Non-Smoker, LSES	Male, 42, currently 'doing nothing', worked as courier occasionally, no children
P33	Non-Smoker, LSES	Male, 33, plumber, white, no children
P10	Non-Smoker, LSES	Male, 35, working in Central London as security guard, white, one child, living in suburbs

Table 4.3 Further details of participants' characteristics of interview sample

Most of the 'lower SES' sample worked in routine occupations such as in offices, few with any extra responsibilities. Those who were not currently working, such as the single mothers I interviewed, had all worked previously, for example, as care workers, cleaners, or receptionists, although they currently depended on benefits (and working for 'cash in hand'). One older female lower SES smoker was on long-term disability/unemployment, having previously worked as a care worker for over twenty years. In terms of structural context, they mainly lived in less affluent areas of London, some of which contained considerable disadvantage in terms of high crime, poor educational opportunities and poverty. However, they also tended to have a heterogeneous population in terms of ethnic minorities and different class groups (e.g. a council estate might be next to middle-class/advantaged neighbours, or mixed in the same road as 'incomers' encroach on old 'deprived' areas). As is typical in much of London, services such as public transport tended to be relatively good, as was their access to facilities such as supermarkets. Many lower SES participants were commuting

into London on a daily basis. Only one of the LSES sample were in the long-term unemployed category of the NS-SEC (Class 8) although four were not working actually at the time. It is therefore categorised as 'working-class' in the sense that the participants were either currently working in a routine semi-skilled or unskilled occupation, or had done so for some length of time in the past. However, some of them, particularly the lone parents on benefits lived in constrained material circumstances. When asked about their 'class', most described themselves as 'working' or 'working-class' although some questioned this e.g. P35 said in response to this question (lower SES male smoker) 'are there any social classes these days?'

All of the 'higher SES sample', bar one who was on sick leave and had then resigned, was currently employed in a professional, managerial or 'creative' type jobs. The exception to this was a sub-population of three postgraduate students in their mid-twenties. It is difficult to generalise about the areas of London in which higher SES participants lived as they vary enormously. However, in the main they either lived in more affluent areas, or in more affluent sub-areas within a poorer area (e.g. within the borough of Clapham there are both affluent and less affluent areas) which have good transport links with Central London. Many of them commuted to work, although a few also were home-workers. In terms of their self-descriptors of 'class', several higher SES participants who were in the 40-60 age group described themselves as 'working-class'. On prompting, they felt this was because they came from a working-class background, even if they currently did professional jobs. The majority described themselves as 'middle-class', 'lower middle' or even 'I don't know'.

It is important to note that the 'lower' SES group in the interview study may differ slightly from those in other qualitative research studies conducted in very deprived areas. For example, Bancroft et al., 2003 had a greater number of 'unemployed' in their

sample compared with the interview sample here. Stead et al., (2001) also emphasised the geographical and social isolation of his participants, whereas although many of the 'lower SES' participants in this sample lived in less affluent areas of London and the South-East containing considerable disadvantage in terms of crime rates or poor health, they tended not to be so geographically isolated, with good public transport links, access to facilities such as supermarkets, and a more heterogeneous class and ethnic minority population.

The majority of participants were obtained through word-of mouth in workplaces/gyms/social situations, followed by a snowballing technique whereby each interviewee suggested other potential participants. Participants were also sourced from the Camden and Islington Smokers' Clinic which is situated in the Department of Epidemiology and Public Health at University College, London. This clinic serves smokers who wish to quit and would like professional help to do so. The database includes over 1,500 smokers and ex-smokers. Potential interviewees were contacted and asked if they would like to participate. The location of the researcher in London meant that those who were currently living in London and the South-East formed the majority of the sample as these were relatively accessible.

4.3.1.3 Sample size

As Patton (1990) points out 'There are no rules for sample size in qualitative inquiry. Sample size depends on what you want to know, the purpose of the inquiry, what's at stake, what will be useful, what will have credibility, and what can be done with available time and resources.' (p.244)

Morse (1994) has suggested that for ethnographies and grounded theory studies, about 30-50 interviews is a good minimum number, though less for in-depth phenomenological analyses (6). 40 interviews were conducted here with the aim of

conducting an exploratory study of smoking identities amongst a sample of UK participants. However, rather than allowing the sample to vary naturally in terms of sub-groups, two ‘theoretically purposive’ sampling criteria (smoking status and socio-economic status) were employed to ensure that these groups were represented in the research population. It was felt particularly important to pre-specify that half the sample (n=20) would come from lower SES groups. Although lower SES individuals are over-represented in terms of the smoking population (Lader & Meltzer, 2004), they are often under-represented in research populations and can be a difficult group to recruit, although this may be due to problems with contact details as much as a lack of enthusiasm for participating (Parry, Bancroft, Gnich, & Amos, 2001). Smoking status was varied to emphasise the contrast in understandings and experience between smokers and non-smokers (n=20). This means that in each of the sub-groups with which the analysis was primarily concerned (such as lower SES non-smokers), the number of participants was n= 10.

Stratified purposeful sampling such as this is used in qualitative research to illustrate experiences of particular sub-groups of interest and to facilitate comparisons as well as examine commonalities (Patton, 1990). However, the aim is not to offer a generalizable sample or be statistically representative of either smokers or non-smokers, nor of lower or higher SES individuals in the UK. Rather what is offered is a qualitatively derived insight and in-depth understanding from a small number of participants who fit these criteria, the characteristics of whom are made transparent in the Methods section.

Finally, time and resources are a necessary consideration within qualitative sampling (Patton, 1990; Sandelowski, 1995). Given that the researcher had to both conduct and transcribe all the interviews herself, there were natural constraints on the number of interviews which could be conducted and analysed in-depth in the time-frame of a PhD.

4.3.1.4 Procedure

The conceptual map/interviews were conducted in late 2001 and early 2002. Participants were interviewed in a quiet room at UCL and all interviews were recorded for later transcription. Participants filled out a consent form and were given an information sheet with limited details of the research and researcher's contact details, in accordance with UCL ethical guidelines. They were then presented with the conceptual map task (shown in Appendix A: 1). This constituted a grid with 4 boxes printed on an A4 sheet of paper. At the top of the sheet were instructions to list all the different images they have of a smoker, placing those they considered to be related together in the same box. Participants were told they could use words more than once in different boxes, add extra boxes or not use all the boxes, and draw pictures as well as using words. They were given 5-10 minutes to complete the map. Having completed the map, the participants were then interviewed according to the topic guide (Appendix A: 2). At the end of the interview, participants were asked to fill in the questionnaire found in Appendix A:5 to assess demographics and smoking status. They were paid £5 for their participation.

4.3.1.5 Analysis

The conceptual map was analysed by calculating the percentage of participants who mentioned one of a set of major themes identified by the researcher, having examined all the maps. This provided an indicator of the spread of the first associations of participants. Striking differences and similarities were then explored.

The thematic analysis of the interviews was conducted with the computer-based textual analysis package, Atlas-ti, commonly used now for qualitative research in the social sciences (Weizman & Miles, 1995). It was used for several reasons. Any analysis needs to encompass the bulk of the data, rather than to select examples that underline

arguments and imply they are typical (Silverman, 1993). Computer packages allow for the handling of greater numbers of interviews and allow for a big enough *n* per cell (10 in this instance) to make useful comparisons. They also allow for increased complexity of thought since they can store and retrieve many more links than researchers can store in their minds. However, they cannot fulfil the central task of textual analysis, which is to decode the text. This has to be done by the researcher with the computer as a mechanical assistant to manage the data. In this interview study, all of the transcribed interviews were read by the researcher and a resultant coding frame developed. This reflected both emergent themes and prior conceptualizations (e.g. social identity processes). The coding frame was carefully operationalized, with each code given a name, a theoretical definition and an example, to ensure consistency of coding (see Appendix B). This coding frame was then applied by the researcher across all interviews. A qualitative analysis and interpretation of the codes followed, focusing on the differences between SES and smoking status groups.

4.3.2 *Q-methododology*

4.3.2.1 *Sampling the 'concourse'*

The first step in Q-methodology is to sample what is 'sayable' about a topic within the culture. This is known as the 'concourse'. The transparency and authenticity of the end accounts is clearly dependent on this process. The aim is to avoid repetition, duplication or ambiguous statements. It is also suggested that the researcher generates many more items (two or three times more) than are finally needed. This ensures that the final 'distilled' items are of a high quality (Stainton-Rodgers, 1991).

The items generated for this study were derived primarily from verbatim statements made by smokers within the interview study, or from pre-existing literature such as 'smoking is my only luxury' (Graham, 1993a). Items were created to cover a) major

topics which the interviews revealed to be central to people's smoking identities and b) areas of contradiction, ambivalence, or areas which although not numerically dominant within the interviews, were judged to be highly emotive or salient (such as pleasure, risk-taking and rebelliousness).

Initially, 155 items were generated. They were given to two current smokers to read. They were asked whether the statements were viewed as authentic for smokers. They suggested that statements concerning the less unarticulated aspects of smokers' identity (such as rebelliousness, risk-taking, pleasure and societal defiance) be reworded. They reported that although they related to the sentiments expressed, the items were 'too blatant'. The difficulty of creating items for these topics undoubtedly reflects their 'unsayability' within the culture.

A process of revision was continued until 70 final items were chosen. A pilot Q sort, using the entire postal pack, was undertaken with two participants. Minor amendments to the instructions were made at this stage. The final Q-sort items can be seen in Appendix A:3 and the Q-sort booklet in Appendix A:4.

4.3.2.2 Participants

As discussed in the theoretical section, Q methodology does not aim to sample a population of individuals in the traditional sense, but rather a population of ideas. However, it is important to gather participants who might have divergent understandings of the issue, in this instance who might have different smoking identities. A priori sampling, as used with the interviews, is not possible for a Q sort as one cannot control who returns their sort. However, criteria can be set for inclusion. In this study, these criteria followed similar dimensions to the interview sample: participants had to be smokers (defined as more than 1 cigarette a day), born in the UK and aged between 20-60 years. Particular attention was paid towards attracting

participants from both higher and lower SES groups. The demographic and smoking status questionnaire was attached to the Q sort booklet (Appendix A:5).

Given some difficulty in attracting lower SES participants to the interview phase, it was decided that this group should be specifically targeted. Approximately 70 lower SES smokers who were registered with the Camden and Islington Smokers' Clinic were invited to participate by letter (with free reply slip). Two adverts were also placed in the print media in regional newspapers with a predominantly CDE (lower socio-economic) readership (Kent Messenger, Essex Chronicle). More than half the final sample came from this source, which proved to be a very effective and quick way of gaining lower SES participants. Some participants were also drawn from the subject database maintained by the Psychology department at UCL. This contains over 400 subjects (including students and non-students) willing to undertake paid research. The overall demographic profile of the Q-sort participants is presented in Table 4.4 below.

Variable name	Categories	Participants no. (%)
Gender (n=64)	Male	24 (38%)
	Female	40 (62%)
Socio-Economic Status (n=64)	Higher	37 (58%)
	Lower	27 (42%)
Age (n=64)	Mean=33.3	
	20-29 years	32 (50%)
	30-39 years	13 (21%)
	40-49 years	8 (13%)
	50-59 years	10 (16%)
Children (n=63)	None	35 (55%)
	1-4 children	29 (45%)
Ethnicity (n=63)	White	58 (92%)
	Black/asian/other	5 (8%)
Age started smoking (n=63)	Mean = 15.5	
No. cigarettes a day (n=62)	Less than 10	26 (42%)
	10 to 20	28 (45%)
	More than 20	8 (13%)
No. times tried to stop (n=62)	Never	12 (19%)
	Once	12 (19%)
	2-4 times	24 (39%)
	5+ times	14 (23%)
In past 5 years, not smoked for...(n=62)	Less than one day	10 (16%)
	1-6 days	14 (23%)
	7 days-1 month	20 (39%)
	More than 1 month	18 (29%)
Desire to quit smoking (n=62)	Not at all	4 (7%)
	Slightly/moderately	24 (38%)
	Quite/very strongly	34 (55%)
First cigarette of the day within...(n=62)	Less than 30 min	27 (43%)
	30 min to 1 hour	11 (18%)
	1 to 2 hours	8 (13%)
	More than 2 hours	16 (26%)

Table 4.4 Demographic characteristics of the Q sort participants

The next table, 4.5 shows the details of every Q-sort participant individually, in terms of their gender, age, SES, occupation, ethnicity, number of children, number of cigarettes per day and the time to first cigarette. These were all self-report measures.

	Gender	Age	SES	Occupation*	Ethnicity	Children	Number of cigarettes per day	Time to first cigarette
P1	Female	33	Higher	Lecturer in geography	White	None	8	2 hours or more
P2	Male	22	Higher	Full-time student, father in City	White/African	None	15	Within 30 min
P3	Female	50	Higher	Looking after home/family, previous occupation as teacher	White	Four	8	30 min-1 hour
P4	Male	27	Higher	Further ed lecturer for adults with learning disabilities	White	None	25	1-2 hours
P5	Male	28	Higher	Youth offending officer	White British	None	25	Within 1 hour
P6	Female	27	Higher	Accountant	White	None	14	Within 30 min
P7	Female	21	Higher	Journalism school	White	None	5	2 hours or more
P8	Male	25	Higher	Fashion designer	Oriental (Chinese)	None	6 to 10	30 min-1 hour
P9	Male	31	Higher	Professional musician/producer	White	None	5-20	1-2 hours
P10	Female	28	Higher	Internet editor	White	None	4	2 hours or more
P11	Male	21	Higher	Full-time student, parents own business	White	None	20	30 min-1 hour
P12	Male	51	Lower	Plumber	White	Four	15	Within 30 min
P13	Male	28	Lower	Parts admin/stock control for insurance co	Missing	None	Missing	Missing
P14	Female	28	Higher	Catering manager	Missing	None	Missing	Missing
P15	Male	24	Higher	Full-time student, owned own business	White	None	10 (+5 joints)	30 min-1 hour
P16	Female	27	Lower	Unemployed	White	None	10	1-2 hours
P17	Male	28	Higher	Designer in fashion	White	None	1-2 a day	2 hours or more
P18	Female	21	Higher	Full-time student, father 'manager' (not specified further)	White	None	5	2 hours or more
P19	Male	22	Higher	Field researcher with children	White	None	5	2 hours or more
P20	Female	21	Lower	Cleaner at school	White	None	7	30 min - 1 hour
P21	Female	21	Higher	Full-time student, father doctor	White	None	3	2 hours or more
P22	Female	20	Lower	Catering assistant	White	None	5	1-2

					European			hours
P23	Female	20	Lower	Assistant at local college	White	None	2	2 hours or more
P24	Female	21	Lower	Classroom assistant	White	None	1-2	2 hours or more
P25	Female	21	Higher	Researcher	White	None	20	Within 30 min
P26	Male	25	Higher	Training to be solicitor	White	None	10	30 min-1 hour
P27	Female	25	Higher	Education recruitment consultant	White	None	5	2 hours or more
P28	Male	59	Lower	Unemployed	British/White	Three	40	Within 30 min
P29	Female	21	Lower	Doctor's receptionist	White	None	10-15	Within 30 min
P30	Male	24	Lower	Lift servicer	White	None	15	Within 30 min
P31	Male	34	Lower	Care provider	British	Two	10	1-2 hours
P32	Male	24	Lower	Double glazed unit fabricator	White	Three	14	Within 30 min
P33	Female	34	Lower	Looking after home/family (no previous occupation)	White	One	20	Within 30 min
P34	Female	46	Higher	Office manager/company director of ID/loyalty card company	White	Two	10	2 hours or more
P35	Female	27	Higher	Independent contractor in marketing/sales for finance company	White	None	20	2 hours or more
P36	Female	44	Higher	Looking after home/family, previous occupation nursery teacher	White	Two	20	Within 30 min
P37	Female	31	Lower	Unemployed	British	Two	20	Within 30 min
P38	Male	60	Lower	Retired on ill-health, former building work	White	None	9-14 but was 40 a day for years	Within 30 min
P39	Female	23	Lower	Customer services assistant/cashier in supermarket	White	Two	15	30 min-1 hour
P40	Male	47	Higher	Computer engineer	White	Two	30	Within 30 min
P41	Male	53	Higher	Self-employed writer	White	One	10	1-2 hours
P42	Female	52	Lower	Disability allowance, no previous employment mentioned	White	One	15	Within 30 min
P43	Male	55	Lower	Undertaker's assistant	Missing	Two	20	Within 30 min

P44	Female	60	Higher	Semi-retired, addictions counsellor	British Asian	Two	15	Within 30 min
P45	Female	50	Higher	Long-term sickness benefit/works as an artist	White	None	5-10 a day	2 or more hours
P46	Female	31	Lower	School receptionist	Greek Cypriot	One	15	Within 30 min
P47	Female	54	Lower	Long-term disability, previously carer	White	One	30-40	Within 30 min
P48	Female	21	Higher	Translator for publishers	Turkish/English, so Asian and White' I guess, which means nothing to me anyway	None	15 a day, 25 when working or drinking alcohol which I don't do quite often	Within 30 min
P49	Male	46	Lower	Long-term disability, no previous occupation mentioned	White	Two	30	30 min-1 hour
P50	Female	46	Lower	Supermarket shop floor assistant	White British	Two	20	Within 30 min
P51	Male	34	Higher	Head of English in secondary school	White	None	20	30 min-1 hour
P52	Female	39	Lower	Looking after family/home, no previous occupation mentioned	White	Two	40	Within 30 min
P53	Female	47	Lower	Part-time carer for elderly	White	One	35	Within 30 min
P54	Female	39	Lower	Looking after family/home, previous bar work, temping, 'you name it'	White	Two	15	Within 30 min
P55	Female	35	Lower	Medical receptionist	White	Two	10	1-2 hours
P56	Male	43	Higher	European export manager in freight	White	Two	15	30 min-1 hour
P57	Female	32	Lower	Looking after the family/home, 'got pregnant straight after school'	White	Four	9	2 hours or more
P58	Female	36	Lower	Looking after family/home, no previous occupation mentioned	White	Four	15	1-2 hours
P59	Male	55	Higher	Sick/Disability allowance, used	White	One	20	Within 30 min

				to be a teacher				
P60	Female	28	Higher	Full-time student, also researcher	White	None	9	Within 30 min
P61	Male	26	Lower	Supermarket cleaner	White	None	10	30 min-1 hour
P62	Female	26	Higher	Research administrator in money laundering section of bank	White	None	1-2 a day	2 hours or more
P63	Female	27	Lower	Secretary in American investment bank	White European	None	2	1-2 hours
P64	Female	31	Higher	Looking after home/family, am teacher	White	One	15	Within 30 min

*Self-described, this formed the basis of the classification of SES according to the NS-SEC (Rose & Pevalin, 2001)

Table 4.5 Table showing demographic details for each Q-sort participant

All participants came from London or the South-East (due to adverts placed in Kent and Essex local papers). They were not visited at home, as this was a postal Q-study, therefore it is not possible to characterise the neighbourhoods in which they live. Data is missing from some of the cells as it was not provided by the participant. It is difficult to know whether these participants forgot to fill it in or turn the page, or it might have been a deliberate act, as some people may not like to provide answers to questions relating to demographic factors.

There are several 'clusters' of respondents (n=64). The first, and largest, cluster of participants is those in employment (n=42), who are divided into 'higher' (Class 1-4) (n=24) and 'lower' SES (Class 5-8) (n=18). There is considerable heterogeneity in the sample. It is not the case that those in lower SES jobs all smoke more or smoke within 30 minutes or waking, and equally some of those in higher SES professions smoke over 20 a day in a dependent fashion.

Another cluster of participants are currently home-based and not in full-time employment (n=17). This could be because they are looking after the home or family

(n=8), either in the context of a break in a career for some higher SES mothers in the sample, or as their primary occupation, for some but not all lower SES mothers. Other participants are at home in the day as they are on sickness/disability benefit or unemployed (n=9). 11 (40%) of those not in work were in the lower SES group and 6 (16%) in the higher SES group. The prevalence of those 'at home' in the day in this sample may reflect their availability to complete a reasonably lengthy task. These also tend to be smokers who smoke a moderate to large amount (15-40 cigarettes a day), plus they predominantly smoke immediately on waking. They therefore constitute a relatively dependent heavy smoker sub-group.

One group is that of students in their early twenties (n=5). They tend to have no dependents. Their SES was defined by their parent's SES, in line with research which shows household (parental) smoking to be the biggest predictor of smoking and difficulty quitting in adulthood (Ferri, 1993; Power et al., 2005). Several mentioned smoking in a social pattern (more on weekend or when out), although one or two do report smoking 20 a day. They were all postgraduates (given the age range of 20-60) and had part-time employment, so were not necessarily in the first stages of their smoking careers.

4.3.2.3 Response rate and sample size

The fieldwork was conducted in 2002. Ninety-four packs were sent out, although four were returned to sender unopened, so ninety packs were received by participants. Sixty-five were returned, which is seventy-five percent of those sent out. However, four were un-usable, being either incorrectly filled out or having statements missing. Sixty-four sorts were therefore entered for analysis, sixty-eight percent of the total sent. This response rate is very good in comparison with other Q methodology studies, which often suffer a reduced response due to the time-consuming and complex nature of the

task (Stenner & Marshall, 1999). In terms of sample size, Brown (1980) argues that 30 is the minimum number of participants necessary to achieve stability in the resulting factor structure. Over fifty (as here with 64 sorts) is a relatively high number of total participants for a Q methodological study (Stenner & Marshall, 1999).

4.3.2.4 Procedure

Participants who responded to the adverts were telephoned by the researcher to explain the nature of the study. This had two purposes. Firstly, the researcher was able to check that they fulfilled the eligibility criterion. Secondly, it was hoped to encourage a greater feeling of involvement in the study which was postal, and therefore perhaps impersonal, in nature. Participants who fulfilled the criterion were sent a study pack. This comprised a consent letter, a subject payment form, a set of 70 numbered statements on card and a study booklet containing step-by-step instructions on how to complete the study alongside the appropriate spaces for their answers. The demographic and smoking status questions were also included. The booklet is included in Appendix A:4 & A:5. A covering letter indicated that they should return the pack within one month. Reminder letters were sent to those who had not returned their packs after one month.

As with the interview study, it was decided to offer a payment for participation. The amount was increased from £5 per interview to £15 per completed Q sort. This was for several reasons: the poor response from lower SES participants to the interviews, the large number of participants to be recruited (60+) and the relatively short time-scale.

A helpline number was provided for participants who were having difficulties with the task. Only two participants rang to request further clarification.

The Q sorting task itself took between 45 minutes and one hour. Participants were told to spread the 70 statements out on a large table or floor, and arrange them according to

how much they agreed (+6), disagreed (-6) or felt neutral (0) about each statement. The statements were sorted into a typical grid pattern. This had a quasi-normal distribution, so that only a few statements would appear at each polar end, under ‘strongly disagree’ and ‘strongly agree’ and many would be placed in the neutral centre. Participants were instructed to spend time moving the cards around to represent exactly what they thought. When happy with their sort, they wrote the number of each statement into the corresponding position in the grid. The grid can be seen on the first page of the booklet in Appendix A:4.

Participants also completed nine sentences: ‘*I strongly agreed with statement _____. The reason was...*’ (x3); ‘*I strongly disagreed with statement _____. The reason was...*’ (x3) and finally; ‘*These statements were also interesting to me _____. The reason was...*’ (x3). In many Q sorts participants are required to comment on every statement (Stenner & Marshall, 1999). This is undoubtedly desirable. However, it was judged that in this instance, where the literacy and commitment levels of participants were unknown, it would lengthen the task too greatly and discourage completion.

4.3.2.5 Analysis

The 64 complete Q-sorts (a 70x70 matrix) were analysed with the aid of an established Q method computer package known as PQ Method 2.11. Initially an inter-correlation matrix of each person’s sort with each other person’s sort is produced (McKeown & Thomas, 1988). Subsequently, the inter-correlations are factor analysed using the centroid method and then rotated orthogonally using a Varimax procedure. The results are presented in Chapter Nine.

4.4 Conclusion

This chapter outlines the rationale for choosing a mixed methodology approach to investigate smoking identities in this thesis. Three methods, within two studies are utilised. The first study comprises a conceptual map to tap first spontaneous thoughts followed by a narrative-based interview to investigate the issues in depth and in participants' own words. The second study uses a Q-sort method based primarily on items taken from the first study to separate and clarify discrete accounts of smoking identities. It is hoped that this use of a mix of complementary methodologies which have at their core the desire to tap the understandings and identities which 'make sense' to participants will yield high quality, triangulated results concerning the 'poor smoker' phenomenon.

CHAPTER FIVE:

CONCEPTUAL MAP RESULTS AND DISCUSSION

5.1 Introduction

This Chapter contains the results and discussion of the conceptual map task which was undertaken prior to the interview in Study One. The conceptual map analysis offers a numerical span of the issues before the qualitative detail is explored in the interview analysis in Chapters Six, Seven and Eight. The focus here is thus on identifying the key salient dimensions of smoker and non-smoker images and identities, as spontaneously produced by participants through their free associations.

5.2 Results of the conceptual maps

40 conceptual maps were completed. One of these was completed by the researcher through dictation due to the participant's problems with literacy.

Each participant produced two maps, one of their images of non-smokers, the other their images of smokers. Table 5.2 and Table 5.3 show the primary dimensions of smoker/non-smoker images. Each primary dimension is highlighted in bold capitals, in descending order of frequency. Thus, for example, in Table 5.2 Aesthetics is the main primary dimension, mentioned by 31 participants, 77.5% of the total sample (8 out of 10 higher SES smokers, 10 out of 10 higher SES non-smokers, 5 out of 10 lower SES smokers and 8 out of 10 lower SES non-smokers).

5.2.1 SES differences in the maps

There are SES differences in the quantity and detail of the images produced. The number of images is calculated according to how many boxes are used by the participant (four were offered, but some participants drew more). The quality of images is calculated by counting how many objects (words/pictures) are used to fill each box.

Participants' status	Smoker Higher SES	Non- Smoker Higher SES	Smoker Lower SES	Non- Smoker Lower SES	Number of participants (Percentage based on total of 40)
Map concepts (most frequent first)	(n=10)	(n=10)	(n=10)	(n=10)	
NEGATIVE AESTHETIC	8	10	5	8	31 (77.5%)
POOR HEALTH	8	9	4	8	29 (72.5%)
NEGATIVE PERSONALITY TRAITS	4	6	3	5	18 (45%)
SOCIAL	5	6	3	3	17 (42.5%)
EXCLUDED GROUPS	3	7	2	3	15 (37.5%)
ADDICTION	6	2	5	1	14 (35%)
STRESS	5	1	4	2	12 (30%)
MEDIA/GLAMOUR	4	4	0	2	10 (25%)
EXPENSE	1	1	2	3	7 (17.5%)

Table 5.1 Dimensions of images of smokers from conceptual maps

Participants' status	Smoker Higher SES	Non- Smoker Higher SES	Smoker Lower SES	Non- Smoker Lower SES	Number of participants (Percentage based on total of 40)
Map concepts (most frequent first)	(n=10)	(n=10)	(n=10)	(n=10)	
HEALTHIER	7	6	6	7	26 (65%)
PERSONALITY TRAITS	4	6	3	6	19 (47.5%)
POSITIVE AESTHETIC	2	6	4	7	19 (47.5%)
INTOLERANCE	5	4	5	3	17 (42.5%)
LESS STRESSED	2	1	1	3	7 (17.5%)
NO ADDICTION	3	0	3	0	6 (15%)
NO IMAGE	0	2	2	2	6 (15%)

Table 5.2 Dimensions of images of non-smokers from conceptual maps

Lower SES participants produce fewer images (2.4 mean images) than higher SES participants (3.2 mean images). Lower SES participants also produce less detailed images (4.5 objects per image) than higher SES participants (9 objects per image). This

may reflect a lower level of educational attainment as discussed in the Methods section (Baker, 2003).

5.2.2 *The primary dimensions of the images of smokers*

As Table 5.2 shows, the primary dimension of the images of smokers is the 'negative aesthetic' with 77.5% of the sample (65% of smokers and 90% of non-smokers) having this as one of their first association with smokers. This comprises two main aspects: smell (e.g. *'pong'*, *'smelly flat'*, *'smelly breath'*) and a negative visual appearance (e.g. *'discoloured fingers'*). Many participants also include the concept of 'dirt' on their maps (e.g. *'dirty'*, *'unclean'*, *'discolouration'*, *'muck'*, *'tar'*).

This is closely followed by the dimension of 'poor health', which has salience for smoking and non-smoking participants' alike (65% v 85%). The key aspects of this dimension are the symptoms of smoking-related ill health (e.g. *'shortness of breath'*, *'heart fast'*, *'wheezing'*, *'heavy cough'*) and the diseases themselves (e.g. *'cancer'*, *'emphysema'*, *'diabetes'* and *'heart disease'*). It also includes a lifestyle aspect (e.g. *'unfit'*, *'not as health conscious as a non-smoker'*) and perceptions of health invulnerability (e.g. *'you don't think you will die young'*).

The third key dimension is that of 'negative personality traits' (45% overall, 55% of non-smoking participants and 35% of smokers). These have two aspects: the selfishness or inconsiderateness of smokers (e.g. *'arrogance'*, *'ignorance'*, *'selfishness'*, *'aggressive'*, *'intimidating'*) and their weakness (e.g. *'emotional crutch'*, *'weak-minded'*, *'anxious'*).

These three negative dimensions are followed by a positive dimension: the 'social' aspect of smoking images (42.5% of the total sample, 40% of smoking participants and 45% of non-smokers). Again, this has two main aspects; the 'good times' (e.g. *'link to*

alcohol, *'relaxation, trance'*, *'nicotine buzz/coffee, cafes'* *'one for the road'*) and the *'group experience'* of being a smoker (e.g. *'good excuse to talk to strangers'*, *'bit of a club'*, *'peer group'*, *'need to fit in'*).

The addiction dimension of smokers' images is also salient for 35% of the overall sample (15% of non-smoking participants and 55% of smokers). This incorporates personality type (e.g. *'dependence'*, *'lack of self-discipline'*, *'addictive personalities'*) and the *'out of control'* nature of their addiction (e.g. *'like drug addicts'*, *'they can't help it'*).

The dimension of *'stress'* also features on the maps of 30% of the sample, for 45% of smoking participants and 15% of non-smokers (e.g. *'stress, anger, impatience'*, *'intense, fidgety'*, *'feel that a cigarette calms them in stressful situations'*).

One quarter of the sample (25%) mention the media and glamorous images of smokers. This dimension encompasses the *'other world'* glamour of the stars (e.g. *'models'*, *'heroes/heroines'*, *'Bogart and Bacall'*) and their attributes (e.g. *'carefree'*, *'cool'*, *'attractive, with movie star looks'*, *'masterful and clean cut'*, *'red fingernails'*).

Finally, 17.5% of the overall sample includes expense as a dimension of the images of smokers (15% of smokers and 20% of non-smokers) (e.g. *'financially penalizing'*, *'waste of money, 'expensive habit'*).

5.2.3 *Dimensions of the images of non-smokers*

There are fewer images for non-smokers than for smokers. Fifteen percent of the sample provides no image at all, with four participants just leaving the map blank and two writing *'no specific images of non-smokers except in contrast to smokers'* and *'not a type, family doesn't smoke'*.

The most salient dimension of the images of non-smokers is their 'healthier status' (65% of the overall sample). The key aspect to this is their healthier lifestyle in terms of exercise and good eating habits (e.g. *'fitness, swimming', 'the gym', 'great physique', 'very fussy about food and wine', 'eating lettuce and drinking mineral water'*). Three participants mention taking this to extremes (e.g. *'slightly anal about everything', 'my body is a temple'*).

The next most frequently mentioned dimension of non-smoker images is their personality (47.5% overall, 35% of smoking participants and 60% of non-smokers). This includes several key features; the achievements of non-smokers (e.g. *'achieve more with their time, work, hobbies', 'more self-control, sensible', 'works harder'*), their greater responsibility (e.g. *'more socially aware and responsible', 'a consideration for their own health and others'*) and their propensity to take fewer risks (e.g. *'more puritanical, smug about no smoking', 'slightly anal', 'sheltered, conformist, low risk takers', 'no drink, no nicotine, no sex?'*)

The images of non-smokers also contain an aesthetic dimension (42.5% overall, 65% of non-smokers and 30% of smokers) which can be summed up by the word 'clean' (e.g. *'clean', 'fresh', 'not dirty'*)

Another salient dimension of the images of non-smokers is their intolerance of smoking (47.5%). This encompasses their judgmental attitude (*'pious, condescending', 'authoritarian', 'intolerant', 'sanctimonious', 'superiority complex', 'opinionated'*) and the signs they use to show this disapproval (*'spluttering', 'coughing if a cigarette is lit within half a mile'*).

Finally, non-smokers are perceived to be less stressed by forty percent of the sample (50% of smokers and 35% of non-smokers) (e.g. *'more balanced mood', 'calmer, tend*

to cope better in a crisis', 'people who are cool, calm and collected') and less prone to addiction (e.g. 'not dependent types').

5.2.4 Specific images of smokers

The above analysis might be thought to suggest that most of the sample simply provide a list of attributes that are relatively unrelated to each other. Some do this. However, a significant number (37.5% overall) include specific images, characters or stereotypes of smokers on their maps. In these images, many associations and dimensions cohere. The 'cast' includes:

The old:

'old man, rollup tobacco, heavy cough, sitting on a park bench, miserable!'
(P5, HSES smoker, male, 20-40 years old)

The young:

'young girl with friends asking for a light, walking along the road chatting'
(P15, HSES non-smoker, female, 20-40 years old)

and The poorly educated/disadvantaged:

'common, tarty girl, chewing gum, young, silly, thick/stupid, working-class'
(P9 HSES non-smoker, female, 20-40 years old)

Other 'characters' to emerge were:

'50's films, hero-heroine smoked, exchanged cigarettes after sex, etc'
(P29, HSES non-smoker, female, 40-60 years old)

'drugs, hippies, peace, scruffy, dirty, scruffy beardy-types, music festivals, unhealthy'
(P26, HSES non-smoker, male, 20-40 years old)

Only a minority of the sample portray these characters graphically (6 out of 40) in the form of a drawing. A sample of these drawings is contained in Appendix C.

5.3 Discussion

These maps were produced spontaneously, with no prior suggestions from the researcher, so might be expected to encompass a highly diverse set of images and associations. However, it is the homogeneity of the images that is striking. Looking first at the map contents of the images of smokers, it is easy to discern a set of key dimensions. Two primary dimensions dominate: the negative aesthetic aspect and the poor health of smokers. With the exception of the social aspect of smoking, all dimensions are negative. It could reasonably be concluded, therefore, that a core, socially shared representation of smokers' identities exists. Furthermore, on this evidence at least, being a smoker appears to constitute a predominantly negative social identity.

It is also striking that there do not appear to be major differences in these dimensions between smoking and non-smoking participants. This is perhaps surprising. The smoking participants are not drawing maps about some abstract 'other' group of people, but about themselves and their own behaviour. It might have been expected, therefore, that they might minimise the negative aspects of smoking identities by excluding them from their maps. This does occur to some extent. Slightly fewer smoking participants tend to mention the negative aesthetics of smoking and the poor health of smokers compared with non-smoking participants. Nevertheless these negative dimensions are mentioned by a majority of smokers. This suggests that the predominantly negative smoking identities contained in these maps represent socially dominant ones of which smokers themselves are keenly aware.

One major finding in these maps is the presence of a 'negative aesthetic' dimension to the images of smokers. It has been argued that smoking is a medicalized behaviour (Penn, 1996). In the light of this, it had perhaps been expected that 'poor health' would

be the dominant discourse. However, the ‘negative aesthetic’ dimension is highly salient. There are several implications of this. Firstly, Goffman (1963) suggests that being stigmatised tends to result in a ‘spoiled’ identity. In this instance, it seems that smokers possess, literally and metaphorically, a ‘dirty’ identity in the eyes of participants. Secondly, the negative aesthetic is highly charged in terms of emotion, through the use of terms such as ‘disgust’. The identification of this ‘negative aesthetic’ suggests a potential basis for stigmatisation which is explored further in Chapter Six.

The uncovering of perhaps unexpected material is an advantage of using the conceptual map as a methodological tool. Participants are free to note down their spontaneous associations and ideas without direction from the researcher. It may also be the case that a free associative technique provides access to less conscious, symbolic material (Joffe and Lee, 2003). The emergence of highly emotional, uncensored negative material concerning the aesthetics of smoking supports this contention. It is arguable that the ‘negative aesthetic’ dimension would not have been so easily revealed by starting with traditional question and answers which often produce intellectual rationalisations (Holloway and Jefferson, 1986).

The ‘poor health’ dimension of the images of smokers is also a dominant one, with the vast majority of participants including it. This gives some support to the contention that lay conceptualisations of smoking are highly medicalized. This dimension incorporates many of the key aspects of the research bio-medical addiction model, in particular the triumvirate of poor health-addiction-stress. The lower SES smokers in this sample tend to mention ‘poor health’ less often than participants in other group. Again, in line with Crawford’s theory, this group has the least to gain by making such an identification as they may themselves be the unhealthiest. They may also not consider themselves

‘unhealthy’ simply because they smoke. These different conceptualisations of health are therefore investigated in further detail in Chapter Seven.

Smokers (from both SES groups) tend to incorporate dimensions of stress and addiction more often than non-smokers. One reason for this might be that these constitute functional explanation of their behaviour which they find useful in terms of self-esteem. By drawing on bio-medical explanations, or ‘disease models’ of smoking such as addiction and stress, smokers may exonerate themselves from the blame attached to health behaviours which are considered the result of ‘moral laxity’ due to their failure to engage sufficient will-power (Ogden, 1997).

Although the images of smokers are predominantly negative, they are not completely so. The most salient positive dimension is the ‘social’. This encompasses both the social context of smoking (pubs, clubs and café’s) and its social benefits of bonding, its ‘conspiratorial’ aspect. This is coupled with a ‘glamorous media’ image of smokers, from ‘Bogart’ to ‘Bacall’. The presence of these dimensions shows that, though the medical and aesthetic discourses are dominant, there are other, more positive, discourses surrounding smokers. It must be noted, however, that it is the icons of yesteryear who tend to be drawn on, rather than stars of today. This might suggest that the ‘glamorous’ image of the smoker is a past rather than a current one.

Lower SES participants (smokers and non-smokers) tend not to include the social/glamorous dimension as frequently as higher SES participants. It is not clear why this is the case. One might have thought that such an association provides a positive aspect of smoking identity for all social groups. One reason might be that higher SES smokers have a more ‘social’ pattern of smoking (Jarvis and Wardle, 1997). Constraints, such as non-smoking working environments, mean that higher SES smokers often consume much of their cigarette intake in ‘social’ situations. They may

also be less dependent on nicotine (Jarvis & Wardle, 1997). There are also identity benefits for higher SES smokers in conceptualising smoking as a 'social' and 'glamorous' activity. It externalises the behaviour, defining it as the result of social context rather than inner compulsion.

The conceptual maps also see the emergence of a culturally available 'cast' who are seen to embody typical 'smoker' traits and behaviours. Thus, for example, the 'old man' appears here to embody unhealthiness (he has symptoms such as breathlessness or a heavy cough), negative aesthetics (he is wrinkly, dirty and smelly) and expense (he is poor). Another common image of the smoker is a young girl with her friends, who carries connotations of ignorance of the health risks, group bonding (peer pressure) and sociability (always with friends). A third image is that of the office worker huddled outside the workplace who embodies stress and addiction. In the conceptual map, they are (necessarily, given the limited nature of the task) stereotypes. However, in the interviews these 'types' often became fleshed out and made real as an aunt, a cousin, or a colleague who exemplifies the aspect of smoking identities the speaker wishes to illustrate.

What is striking about these 'typical' smokers is that, with the exception of the 'social smoker' they are primarily drawn from social 'out-groups'. Smokers are associated with the old, the young, the poor and the uneducated. Crawford has argued that the identification of the 'unhealthy' in our society is not random (1985). 'Unhealthiness' is projected onto less powerful, already stigmatised groups, for example, in the case of HIV/AIDS, foreigners and gay people. It seems plausible that a similar process is occurring here in the context of smoking. The 'unhealthiness' which smoking represents finds its embodiment in excluded social groups, particularly the old, the young and the

disadvantaged. The implications in terms of multiple stigmatisations for lower SES smokers are considered further in Chapter Six.

In contrast to the dimensions of smokers' images, the images of non-smokers are, on the whole, positive. Non-smokers are identified as healthier, less stressed, not addicted and cleaner. They are also seen to have positive personality traits, such as having greater responsibility and greater achievement. This fits with Crawford's thesis that those groups that exemplify socially desirable values such as achievement and personal responsibility through the medium of health (such as non-smokers) are more highly valued.

The dimensions of the non-smoker images are clearly opposite to those of the smoker. As the smoker is labelled 'dirty', the non-smoker is labelled 'clean'. This is partly due to the nature of the conceptual map task which divides the maps of smokers and non-smokers onto two separate pieces of paper. This sets up an oppositional counter-point between the images. It may also reflect the fact that many participants found it difficult to fill in their non-smoker maps. Indeed, fifteen percent of participants left them blank. When questioned about this absence of images, it emerged that many participants view non-smokers as 'normative' and thus not easily labelled through difference. This view of non-smoking identity as the 'norm' undoubtedly reflects the mature status of the smoking epidemic in the UK where the majority do not smoke and those that do mostly want to quit (Jarvis and Wardle, 1997). The labelling of non-smokers as 'normal' suggests that smokers are viewed as the 'Other' and in possession of a compromised social identity.

SIT theorises that one legitimate response in the face of being labelled 'other' is social creativity; to find points of positive distinction for one's out-group (Tajfel & Turner, 1986). There is some evidence of this here. Non-smokers are identified by a small

number of participants as low risk-takers who are 'anal', 'puritanical', 'conformist' and 'sensible'. By implication, therefore, smokers are those who enjoy life and are prepared to take risks. Only higher SES participants (both smokers and non-smokers) tended to make these associations. This characterisation of non-smokers may have little resonance or salience for lower SES groups. It may also be a function of the less detailed maps produced by lower SES participants which did not include all of the nuances of non-smoker identities.

Although non-smokers are primarily viewed in these maps in opposition to smokers, there is one exception. Non-smokers are not characterized as anti-social or less social than smokers. This suggests that although being social is integral to smoking identities, non-smokers are not seen as anti-social for not smoking, as perhaps one might for not drinking. Rather non-smokers are identified for their 'intolerance'. Interestingly, non-smoking participants tend to point this out as readily as smoking participants. This suggests that this is a widely recognized feature of the 'typical' non-smoker. Furthermore, it implies that non-smokers do not see intolerance towards smokers as something they should distance themselves from. Intolerance of smokers is, like their non-smoking status, 'normative'.

Indeed, the enthusiasm with which participants approached this task gives some pause for reflection. There was little attempt to appear politically correct and both smokers and non-smokers often wrote long lists of undesirable traits that they associated with smokers. For example, this non-smoking nurse in her fifties writes:

'less attractive, not fanciable, keep at arms length, lowers my opinion of them, I feel almost instant annoyance at having to breathe smoky air, less likely to make or keep a friendship with them, no self-control, less intelligent, care less about what they are doing to themselves and to their children, inconsiderate behaviour especially if they smoke in public areas such as restaurants, slightly more acceptable in males than females'

Participant 27, Non-smoker, Higher SES female, 40-60 years old

Several participants subsequently reported feeling 'bad' to have put such negative connotations on paper. This suggests that for the most part, having intensely negative images of smokers is not considered 'wrong', but when called to account by an external source (in this instance the researcher) provokes concern about appearing prejudiced. The current stigmatisation of smokers' identities in England is examined in greater depth in Chapter Six. For now, it is simply enough to note that these predominantly negative images were so effortlessly and openly produced, which in itself speaks volumes about the accepted nature of the stigmatisation of smokers.

Only a minority of participants used drawings to illustrate their images. A sample is shown in Appendix C. No one image or symbolic concept predominates. However, each illustration encapsulates the image the participant is trying to represent in a very immediate and perhaps unconscious way. Take, for example, 'One for the Road', which captures the frequently expressed relationship between drinking and alcohol (Appendix C, Map B). The drinker is shown (perhaps significantly) with their back to the viewer, with a cigarette in the left-hand and an old-fashioned pint glass in the right. He is clearly in an old-style pub rather than a trendy bar. It is entitled 'One for the Road', an expression that was never used in any of the interviews. It refers to having just one more drink with the lads before you go home to 'The Wife' or 'Her Indoors'. It could be considered quite dated, both in the sense of this smoky and boozy enclosed all-male environment of the old-style pub and the reference to drinking and driving. The interview subsequently revealed that this lower SES smoker felt part of a different era, in which it was fine for a working-class male to get his hands dirty in manual labour (as a welder) and go down the pub for a pint and a fag before going home. It is a world which is now disappearing, but it is beautifully encapsulated in this symbolic picture.

Another highly symbolic image is that of Death provided by a lower SES smoker (Appendix C, Map D). He has drawn a coffin with RIP on it and at the side is a man who looks like a skeleton or skull's face that has what appears to be a stench rising off him with the word 'pong' written at his side. This illustrates perfectly the intertwining of the two main dimensions of smokers' images: negative aesthetic and poor health. Indeed, this picture seems to indicate that for this participant at least, the smell of smoke represents the smell of death.

The advantage of encouraging participants to include drawings is their symbolic and metaphorical resonance. The conceptual maps did also encourage creativity and less linear thinking, for example, several participants drew mind maps, diagrams or linked items through arrows. The conceptual map thus became for many a working tool for the mind and the subsequent interview all the richer as a consequence.

There are also disadvantages to the conceptual map task. Firstly, it can be difficult to deconstruct and decode people's simple line-drawings. Secondly, doing drawings was not popular with most participants. Thirdly, there is a limit to what can be read into the contents of the conceptual maps. Although one can draw tentative conclusions about the free associations of the participants, ultimately many of the topics only become clarified during the interview. Finally, and importantly in this context, there are SES differences in the quantity and detail of the images. This type of creative brainstorming may feel more natural to higher SES participants; alternatively it may be that the educational level of participants plays an important factor in the richness of the data.

5.4 Conclusion

These results suggest there is a relatively homogenous social schema of smokers which is predominantly negative. In this schema, non-smokers are essentially seen as normative, the benchmark of health and positive life values against which smokers are

measured and found wanting. It is smokers who therefore have to account for themselves and their actions. This goes further than simply making negative attributions about smokers; the link between excluded 'out-groups' and smokers suggests that their status as 'Other' leaves them open to stigmatisation. The conceptual map analysis has provided a numerical 'span' of the salient dimensions of smoker and non-smoker images. The results of the in-depth interviews, based on these maps, are now presented.

CHAPTER SIX:

INTERVIEW RESULTS AND DISCUSSION OF ‘THE STIGMATISED SMOKER’

6.1 Summary of chapter

This analysis chapter considers the social disapproval and stigmatisation of smoking identities as evidenced in the interviews. It is divided into four sections. The first considers in more detail the aesthetic dimension of smoking identities, such as smell and appearance and considers the ways in which these are used as identifying markers. The metaphor of pollution, contamination and risk to others through passive smoking is also examined here. The second section looks at the identification of smokers with ‘other’ excluded groups. The third section considers the experiences of implicit and explicit social disapproval from the point of view of the ‘perceiver’ (non-smokers) and the ‘target’ (smokers). Finally, the fourth section then considers how smokers manage this social disapproval in terms of coping mechanisms. The differences between lower and higher SES groups in their perceptions of social disapproval and stigmatisation in relation to ‘being a smoker’ is highlighted throughout.

6.2 Results: Identifying markers, contamination and risk to others

Chapter Five showed that negative aesthetics, in particular smell, was the most common association with smokers. The dominance of this theme is continued throughout the interviews. Non-smokers of both lower and higher SES hold similar conceptualisations; these are therefore presented together. There are some differences between lower and higher SES smokers’ conceptualisations; these are highlighted where appropriate.

6.2.1 Non-smokers

Looking first at the conceptualisation of the negative aesthetics by non-smoking participants, 'smell' emerged very strongly as the major theme. It was mentioned by the vast majority of interviewees with no differences between SES groups. The tone of the discourse can be discerned from the types of words used to describe the smell which are predominantly negative; 'reek', 'stink', 'pong', 'stale', 'old', 'distinctive' and 'strong'. For many non-smokers, smell is the single most salient feature of smokers. For example, this non-smoking gym receptionist (lower SES) describes her perceptions of smokers when on a night out in London:

'It's just their whole persona, it's the whole person IS the smoking. And this bubble is just what they walk around in...I know a lot of the time they are not conscious that they are in this whole smoking bubble'

Participant 39, Non-Smoker, Lower SES female, 40-60 age group

The smell is the subject of strong negative emotions on the part of non-smokers, who described it in terms of 'repellent' 'dislike', 'irritation' 'feel sick', 'gagging', 'unpleasant', 'stifling' 'awful', 'want to heave' and 'disgusting':

'It's that musty smell that really gets to me, you know when people are too close to you on the Tube and it's like [makes gagging sound]. It's 'oghhhh' cos it's very strong, it's almost enveloping you, you are trying to ignore it and eventually you get used to it and then it won't be there. It's only when somebody suddenly moves close to you and you are 'oghhhh' again'

Participant 36, Non-Smoker, Lower SES female, 20-40 years old

Many non-smoking participants agreed that you can often tell who smokes by their smell. Thus smell constitutes a 'marker' of smoking, as Participant 39 continues:

'Unlike with drink and drugs, you can tell a smoker as soon as you see them, their breath if they have recently had a cigarette, you can smell it on their breath, or even if you are not face-to-face with somebody you can smell it on their clothes'

Participant 39, Non-Smoker, Lower SES female, 40-60 years old

Another aesthetic marker of being a smoker for non-smokers is a negative appearance, in particular the skin which is described as 'grey' 'dry and 'wrinkly' 'leathery', 'fingers' which are 'red' 'yellow' 'nicotine-stained' or 'scarred' and 'brown teeth'. These are primarily signs of premature aging; thus smoking is linked negatively with old age and decay. Not all smokers are seen as having these particular markers, mostly those who are heavy smokers or older, as this non-smoking senior staff nurse (higher SES) in her fifties explained:

'You do notice very gravelly voices in females, they get a deeper voice along with the poor skin and their mouths never seem as health looking, their teeth look a bit brown...I could virtually pinpoint all the ones that smoke, definitely from the ones who don't smoke by the look of them, they don't look fresh and healthy, they've got a staleness about them'

Participant 27, Non-Smoker, Higher SES female, 40-60 years old

The metaphor most associated by non-smokers with smoke is pollution. Smoking is frequently spoken of as a 'dirty' or 'filthy' habit, the ash as 'dirty', cigarette butts as 'litter' and 'rubbish' and the smoke as 'polluting', 'toxic' or a 'poison' creating a 'fog'. Such pollution is often described as unnatural or against nature:

'You are taking something into your body that is not natural and that you don't need. If your body doesn't need it, it's like a toxin going in, your body can't cope and then it starts shutting down or whatever'

Participant 24, Non-Smoker, Lower SES female, 40-60 years old

The concept of smoking as pollution in turn carries associations of 'dirt' and 'lack of cleanliness'. Smokers' identities are dirtied by this association:

'It all conjures up an image I think to other people that they don't look after themselves physically. I think they just don't look after themselves, I don't know, it just repels me personally'

Participant 9, Non-Smoker, Higher SES female, 20-40 years old

This pollution is not just of the self, but the pollution of the environment around smokers:

'The unclean bit is to the environment that you are in, your work-place, your house your sofa, your car, and your own ash down to you, cigarette stains on your finger, the whole thing is an unclean habit'

Participant 33, Non-Smoker, Lower SES male, 20-40 years old

This pollution metaphor also incorporates the notion of 'contamination' to explain how smoke affects other people through passive smoking. For example, this non-smoking secretary who regularly travelled on the Tube revealed her (usually unarticulated) fear of contamination from the smoke of others:

'When I am standing behind someone and the smoke is coming in my face, I don't really think about the health side of it at all, really, I think oh god, that's been in your body, I don't want it in mine now. I think it's dirty. It's not just smoke, it's second-hand smoke cos it's been down your lungs, in your mouth and now it's coming into my body. I never said that before, I don't think anyone else would even say that, but that's what I think'

Participant 25, Non-Smoker, Lower SES female, 20-40 years old

In this conceptualisation, smoke contaminates people's clothes, homes and enters their personal space and as such represents an invasion of their privacy and a contravention of their 'right' not to be contaminated. Again, Participant 39, the gym receptionist who defined herself as 'anti-smoker' spoke about this dislike:

'Even though I am not a smoker, they still manage to get onto me and my personal area and my personal property as well. It's not like getting into a fight and someone ripping your clothes, it's not that high a level, but it's on the same level of somebody's coming ...I feel that's obviously quite degrading as well, because what you're being asked is for someone to come into your personal space and has dirtied it so to speak'

Participant 39, Non-Smoker, Lower SES female, 20-40 years old

In terms of rationally calculating the health risk of this contamination, non-smoking participants tended to feel passive smoking was less risky than actually smoking by some considerable margin, but that it did increase the risk slightly, depending on the circumstances:

'This whole passive smoking thing, yeah, if I go to the pub and everyone is lit up and I'm breathing that in, I'm divvying up the risk with the other people, there're all getting a slice of the carbon monoxide'

Participant 10, Non-Smoker, Lower SES male, 20-40 years old

Any rational risk assessment of such contamination is not neutral, however, but accompanied by very strong emotions, particularly a sense of invasion and feeling of disgust:

'It makes me feel physically sick that someone has just polluted me with their smoke'

Participant 39, Non-Smoker, Lower SES female, 20-40 years old

It is also the subject of some moral censure, particularly towards smokers who are perceived not just to contaminate themselves and other adults, but 'innocent others' such as children or babies who are perceived to be at greater risk. Participant 27, the senior staff nurse in her fifties found this particularly hard to understand as a mother herself:

'I do think it is inconsiderate when mothers smoke in front of their children, again that really annoys me when you've got mothers who smoke and their children are suffering with psoriasis and eczema in particular and it definitely makes things ten times worse, and I think they've no right to do it in front of their children.'

Participant 27, Non-Smoker, Higher SES female, 40-60 years old

6.2.2 Smokers

This section considers how smoking participants construct the issues of smell, pollution and risk to others. Invariably such perceptions respond to the perceived negative discourse from non-smokers. It will be seen that smokers often distance themselves from the negative aspects of smoking identities through minimisation and de-emphasis of certain aspects of the discourse. Subtle differences also emerge between lower and higher SES smoking participants.

Smoking participants in both SES groups showed an awareness of the markers of smoking, for example, they did not defend themselves against the allegations of smell.

However, to some extent they mitigated their responsibility for this negative connotation by indicating that sometimes they were not aware of it themselves:

'The strange thing is that as a smoker, you really don't smell it...it's seen as a dirty habit, it's a disgusting habit and it's a bizarre thing that as a smoker you're not that aware of it'

Participant 18, Smoker, Higher SES male, 40-60 years old

Smoking participants also did not tend to dispute that negative appearance markers of smoking exist. However, no higher SES smokers identified themselves personally with this negative aesthetic, rather distancing themselves by associating it with other 'older, heavier' smokers. For example, this young female post-graduate student (Participant 2, higher SES), who mainly smoked on weekends, distanced herself from 'other' women smokers:

'I'm conscious of it actually from an aesthetic point of view, the fact that it will make my skin age and I look all the time at heavy smokers and the girls definitely have more wrinkles and you look at older women and I think you can spot an older woman that has smoked just by the colour of their skin and the type of wrinkles that you get, but I think that you have to be a heavy smoker'

Participant 2, Smoker, Higher SES female, 20-40 years old

Several lower SES smokers, on the other hand, made a personal self-identification with this negative aesthetic and themselves. For example, Participant 7 was a 37 year old porter who, as a 40 a day smoker, looked older than his age suggested as he himself acknowledged:

'It's just the looks, like the crows feet under the eyes, they look more haggard than normal, you know, that's how you can tell. I suppose I'm the same though'

Participant 7, Smoker, Lower SES male, 20-40 years old

As with the non-smoking participants, smoking participants also drew quite extensively on the pollution metaphor to conceptualise the effects of smoke. However, they did this in different ways. For example, smoking is frequently described as a 'dirty habit' by smoking participants. However this tends to constitute an acknowledgement that

smoking can be perceived as such rather than the vehement expression of disgust that it was for non-smokers.

'It's thought of as dirty, disgusting, can't understand why you'd do something so stupid to yourself, on one hand by one set, but I think there's another set what would say ummm, what you do is your own business'

Participant 4, Smoker, Higher SES male, 20-40 years old

The metaphor of pollution is also drawn on to justify or minimise smoking behaviour, and thus culpability for it. It was often argued, by higher SES smokers in particular, that the pollution caused by their smoke has to be balanced against other types of pollution, such as environmental or traffic pollution:

'I mean as dangers go, I think there are many more dangers immediate, perhaps like loads of pollution, incredible levels of pollution which are far more damaging, I don't put passive smoking on that level at all'

Participant 6, Smoker, Higher SES female, 20-40 years old

Furthermore, several higher SES smokers also pointed out that pollution from smoking is demonised in a way that other types of pollution, and polluters, are not:

'Yeah, ok, it is a disgusting habit and it's smelly and everything, but so is belting out crap from cars and I don't drive, so I'm sure more crap comes out of people's cars driving to work than the sort of crap I put in the atmosphere. Being a smoker is a habit that you have to hide, whereas driving a car that is a horrible polluting thing, that's fine, that's ok'

Participant 37, Smoker, Higher SES female, 40-60 years old

Higher SES smoking participants also tended to estimate the rational calculation of health risk to non-smokers as relatively low, again a strategy of minimisation. No higher SES smoker thought that the risk was equal or greater for non-smokers and most thought passive smoking constituted very little or no health risk. For example, this male political scientist who tended to smoke heavily in social situations said:

'I'm not sure about this passive smoking stuff. I'm not sure to what degree other people are really at risk. I'm not saying my mental narrative would be 'I'm putting them at risk' it would be 'they've got a right to be in fresh air and I don't

have a right to pollute that air for them', so it's more about their comfort, it's not a health risk'

Participant 4, Smoker, Higher SES male, 20-40 years old

Higher SES smokers also de-emphasised the risk to children and babies from passive smoking by mentioning it less frequently than the other groups. They also avoided personal moral censure as no women in the higher SES smoker group detailed smoking whilst pregnant:

'As I say, because there are more and more smoke-free environments I'm not sure that the effect on children, because that would be the obvious group that you tend to think about, but I think their exposure to smoke is vastly reduced now'

Participant 18, Smoker, Higher SES male, 40-60 years old

On the other hand, the position of the lower SES smokers in the sample tended to be one of acceptance or internalisation of their status as a 'risk' to others. Without exception, for example, all the lower SES smokers in this sample volunteered the information that their smoking poses a risk:

'People around you, people in smoky environments [are at risk]. Say you are in a club and you are a musician like that guy [Roy Castle] who died some years ago and he was never a smoker and he was working in a smoky environment and even though he didn't actually smoke, the smoking killed him because obviously he was inhaling everybody else's smoke. That alone can kill a person'

Participant 21, Smoker, Lower SES female, 40-60 years old

Lower SES smoking participants also tended to identify the level of this risk as reasonably high. Indeed, several thought it was actually equal or higher for non-smokers than for smokers. For example, this participant on incapacity benefit was practically house-bound, so was concerned about the effects of heavy smoking on her pet:

My dog, my poor dog [is at risk]. Non-smokers I think, from what I've read and seen on the TV the effects of smoking are more serious for a non-smoker inhaling it, secondary smoke, than someone who smokes'

Participant 20, Smoker, Lower SES female, 20-40 years old

The lower SES smokers were also less able to escape the potential moral censure which accompanies the contamination of 'innocent others'. The vast majority of the women smoking participants in the lower SES group did smoke whilst pregnant. They tended, however, to emphasise the difference in societal attitudes 'back then' perhaps to compensate for their own sense of guilt and the moral disapproval of others. This 39 year old mother of two who worked as a part-time cleaner confessed:

'I smoked with both of mine, you know, it wasn't out then. JP, I was 19 then and it wasn't a big thing then, and he was born fine, but then E was born six weeks premature, his lungs weren't developed. I gave birth to him and he stopped breathing and he was rushed to intensive care and he was there for a couple of weeks and the doctor couldn't figure out why he was born prematurely, it was put down to probably smoking'

Participant 19, Smoker, Lower SES female, 20-40 years old

In summary, the negative aesthetic of smoking was a dominant theme in the interviews. Non-smoking participants from both SES groups offered a relatively consensual perception of smoking as a pollutant which contaminates both the smokers themselves, with connotations of dirt and uncleanness, and those around them, for which they are condemned as morally culpable. Any attempt at rational risk assessment is dwarfed by the very strong emotional response of disgust towards this 'dirty' habit. Although smoking participants acknowledged that there was a discourse of negative aesthetics surrounding smokers, higher SES smoking participants tended to minimise or challenge the more unpalatable aspects of this discourse, whereas lower SES smoking participants tended to internalise it.

6.3 Results: The identification of smokers with 'The Other'

Many participants identified groups naturally and unprompted in their conceptual maps as detailed in Chapter Five. All participants were then asked as part of the main interview which social groups or groups of people they associated with smoking, and to recount stories, experiences and incidents which sprang to mind as a result. The

discourse about groups is therefore grounded very much in participants' lives and experiences rather than simply constituting an abstract or stereotypical list. This section presents detailed findings of an association between smokers as a social group and 'Other' out-groups: the old, the young, women, the poor/uneducated and those on the margins of society.

6.3.1 Older Age

As the conceptual maps showed, old people are one group easily associated by all participants with being smokers. There were no major differences between SES or smoking/non-smoking participants. The primary connotation with age is poor health:

'This old person is probably a little bit related to my granddad because he smoked a lot through his life, he hasn't been diagnosed with cancer, I suppose he doesn't have cancer, but I do know my aunt's father-in-law died horribly of lung cancer at about the same age'

Participant 9, Non-Smoker, Higher SES female, 20-40 years old

Elements of addiction, and the poverty that it might cause, are also connected with the images for some participants. This male security guard working in a Central London office identified the 'scruffy' older people who hung about outside where he worked:

'Someone 50 plus who's just been smoking all their lives, can't give it up, probably moved onto roll-ups 'cause they are cheaper, that's just the sort of image, you see it all the time where I'm working now.'

Participant 10, Non-Smoker, Lower SES male, 20-40 years old

The other key aspect of the image of the older smoker is the context in which they started and continue to smoke. Their smoking identity has gone from acceptable to unacceptable, positive to negative within their lifetime as a consequence of societal changes in attitudes towards smoking. Thus in the main participants did not hold older people as responsible for their behaviour or subject them to moral censure as with some other smokers:

'People in the older generation, people over fifty, no, sixty or more, well it was considered years ago to be quite trendy and they have got into the habit and they find it more difficult to give up. My Nan smokes, my dad smokes, all my dad's family smoke. When I look at people my own age, there's not that many at all, to be honest. I think we are more aware of what's going on'

Participant 24, Non-Smoker, Lower SES female, 20-40 years old

However, although not held morally responsible, the older poorer smoker functions as an unpleasant 'horror' figure for young middle-class smokers in particular. This is perhaps because they embody many of the negative aspects of smoking identities:

'And the fact that they've got a huge great big wedge of ash on the end of their fag looks quite dirty. It obviously an old person who is still smoking, so that's quite depressing really, and it doesn't seem so bad when young people smoke, because they are healthy, but old people smoking is really horrible'

Participant 2, Smoker, Higher SES female, 20-40 years old

The only group of participants who did not identify older people in their discourse about the social groups associated with being smokers were the smokers aged forty to sixty years old. It may have been that this negative image of smokers felt uncomfortably close for them; they distanced themselves by simply not mentioning it.

6.3.2 Youth

At the other end of the spectrum, 'the young' were also associated with being smokers by participants from all groups. Indeed, the identification of the extremes of age was common. It serves as identity work as boundaries are drawn between smokers and both the 'self' ('not me') and one's social group ('not my group'):

'I have a picture in my head of certain groups and one is of young stupid girls but then later on after that my other one is of an old person and I have very young people and very old people, but I don't tend to equate it with people like me, or my age, or in my circumstances'

Participant 9, Non-Smoker, Higher SES female, 20-40 years old

Looking specifically at the image of the 'young smoker', the main image is one of a school or underage teenager who perceives themselves to be 'cool' or 'rebellious' by

their smoking behaviour. It is strongly associated with giving into peer pressure and weakness by this male participant who was fifty-five years old:

'They just buy into the whole thing of it being cool and also the fact that they probably started at a relatively young age, as a result of peer pressure, again that's a sign of weakness in my mind, if somebody tells you have a smoke, it will make you cool or make you tough... if they were stronger-willed or had more of an individual streak to them, they would probably say no'

Participant 32, Non-Smoker, Higher SES male, 40-60 years old

It is thus a relatively 'knowing' portrayal on the part of the participants who are all adults and therefore distanced from this naiveté and impressionability.

An additional and quite different image, of a 'young smoker' is offered particularly by higher SES smoking participants. They identify an attractive, trendy young smoker who can be seen smoking in clubs and bars. For some, this is a clear self-identification with what one higher SES postgraduate student termed the 'nicer' side of smoking:

'You get youthful, particularly women smoking and you wonder how they can smoke so much and look so good cos it does have an effect on your health'

Participant 5, Smoker, Higher SES female, 20-40 years old

As such, it establishes young smokers as 'trendy' and sociable and thus as distanced as possible from the image of the decrepit old smoker. This participant, a freelance writer, lived in Camden in Central London:

'There's a bar up the road from us, it's not really a pub because it's now a converted restaurant, it's now like one of these slightly trendy bars, and Friday evening you walk past and it's packed full of people, probably about your age, perhaps a bit younger, perhaps a bit older, all meeting up and they are all smoking'

Participant 13, Smoker, Higher SES male, 40-60 years old

6.3.3 Gender

The salience of women smokers was clear throughout the interviews. Women smokers appeared in many different guises, and rarely in a positive light. The most striking example of this is the claim, repeated in all SES and smoking status groups that more

young girls and women smoke than men. A sizeable minority (approximately one third) mentioned this perceived disparity, with no-one mentioning that they thought boys or men smoked more than women:

'I think more girls are smoking more than boys these days in the younger groups, and I think even the boys would say there are more girls that smoke than boys to be honest...if you are at home when all the school children are coming out of school, I'm more likely to see a girl smoke than a boy, like in groups. Sometimes I say to my partner 'the girls are worse than the boys now'

Participant 25, Non-Smoker, Lower SES female, 20-40 years old

Sometimes this perception appears to be the results of people's assessment within their own environment. For others, this is a perception perpetuated through the media:

'I've heard on the radio and read in papers that more young girls are more likely to smoke than drink to excess whereas young boys possibly the other way round...I heard that on the radio a couple of times actually on radio programmes, that it's a particular worry that teenage girls are more likely to smoke than young boys'

Participant 10, Non-Smoker, Lower SES male, 20-40 years old

Another group of females who has high salience for all groups is the smoking mother. The identification and moral censure of those who harm 'innocent others' was noted in the last section. However, it is striking that the smoking parents identified are, without exception, mothers even apart from the context of smoking in pregnancy. Smoking fathers are rarely mentioned, in the context of harming others at least, as this non-smoking father of one indicates:

'There is a Croatian girl upstairs that I have known for years and years and I saw her downstairs smoking for the first time and I had no idea that she smoked and it really shocked me and I was quite surprised with that, as it didn't go with her, I didn't think it went with her image cos she's a mother and stuff and I think it's important that they are a good role model, I don't really like smoking mothers for a start.'

Participant 26, Non-Smoker, Higher SES male, 20-40 years old

It is clear that for many, women smoking, especially attractive or young women, are either striking or incongruous in some sense. They don't 'fit' with other predominantly negative aspects of smokers' identities:

'You know, most of them are women actually, they are very well-dressed, they might have very good jobs and they, sort of like, it's kind of funny to see somebody standing around a corner propping up a wall having a fag dressed to the nines, so it's sort of like somehow it's strange. Perhaps I shouldn't be surprised at all'

Participant 6, Smoker, Higher SES female, 20-40 years old

A minority go further than this and admit they actively dislike women smoking. The main objection appears to be that female smokers transgress the identity of the 'ideal female' in some sense. This prejudice against women smokers was not confined to non-smokers, for example, this young male who went out clubbing frequently on weekends with a gang of other lads remarked:

'Me and my cousin have said before, we don't like girls that smoke. I know that sounds thingy, but if you see a girl, I don't know, do I sound like a sexist pig? We wouldn't go up to girls and chat them up if they were puffing, sort of thing. Tarty, yeah, tarty, that's what it does for me'

Participant 40, Smoker, Lower SES male, 20-40 years old

6.3.4 Working-class/Disadvantaged

Another major social group associated with being smokers are working-class and/or disadvantaged groups. The conceptual map analysis showed that only higher SES non-smokers identified this social group spontaneously in their conceptual maps. Indeed, this group proved the most vociferous in their identification of the 'poor smoker' in the interviews.

One aspect of this identification concerned the perceived lack of education or intelligence of smokers in the light of their disregard for health messages. Only higher SES non-smoking participants tended to make this association and often acknowledged that it was not rational or politically correct:

'I know it's an awful thing to think they are less intelligent, as I know they are not. There is one part of me that thinks, oh my god, if they are going to do that, they are obviously not that much in control of their own lives and it's a wrong thing I know, but to reel off pointers, that just came out. It's not rational, really'

Participant 27, Non-Smoker, Higher SES female, 40-60 years old

This lack of education or intelligence, however, does not make them sympathetic.

Rather less educated smokers are judged at a moral level for their lack of responsibility:

'The more uneducated, the less well-off people are, the more likely they are to smoke and damage their own or their children's lives. If the children are unborn for example, the mother's smoking has an effect and it affects the money that can be spent for food'

Participant 10, Non-Smoker, Lower SES male, 20-40 years old

Higher SES non-smoking participants used a variety of terms: 'poor council house tenants', 'lower class benefits kind of image' 'low income' 'poor' 'working class and unemployed' 'working class, hard-worked, outdoor worker' and 'poorer social background'. Asked to account for this association, many argued it stems from their own experience of being around a lower number of smokers in their own social milieu. Participant 9 was a young woman (aged 28) who worked in a well-paid job as a risk consultant and considered herself typically middle-class:

'I regard myself as middle-class and I would say, in my experience, I only have to start to look around, well, there's T [female friend], but to be honest, she's from quite a working class background, but when I look at my friends, my family, there just aren't any smokers at all'

Participant 9, Non-Smoker, Higher SES female, 20-40 years old

Such identification also may have considerable social identity benefits for higher SES non-smokers by distancing them from these negative associations, including transgressing moral boundaries, the perceived misuse of money and a lack of control and responsibility in life. Thus Participant 9 continues:

'When I worked at the bank, people who were really poor, when you came to look at their budget plan, they were spending £40 a week on cigarettes, but they couldn't afford to pay their direct debits. And just when you look around, it doesn't tend to be the people who are well-dressed and on their way to the office

who are smoking. It tends to be people...in my prejudices or something. I spot the people who are hanging around a bit with nothing to do and are shabbily dressed and don't seem to have a lot of money'

Participant 9, Non-Smoker, Higher SES female, 20-40 years old

Often more than one marginalised group was identified; in this instance the participant finds young working-class mothers salient. This confounding of marginalised groups may augment the strength of the negative associations:

'I guess that when I am in these sorts of areas I'll see mothers smoking and their children smoking, I'll see everybody in that area has to have a fag in their mouth and inevitably they are poor and working-class. That's the impression I get when I am walking around sort of the streets of London in certain areas, seeing little fourteen year old girls smoking away or a sixteen year old pushing a pram, she's got a fag in her mouth'

Participant 32, Non-Smoker Higher SES male, 40-60 years old

Lower SES non-smokers tended to also have an association between negative attributions, class and smoking, but mentioned it less frequently than the higher SES non-smokers. They also managed to distance themselves from this negative social identity by identifying 'other' more disadvantaged groups within the overall 'working-class', for example, this 42 year old male was keen to emphasise that although he worked only occasionally, he was not the same as the unemployed smokers:

'It's my area, it's a few people in my area who are unemployed, so probably people who have nothing to do with their time, sitting around somewhere, or in the house or park-bench, it passes the time. Instead of doing nothing, they smoke a few cigarettes'

Participant 17, Non-Smoker, Lower SES male, 20-40 years old

Looking now at the association of being working-class and a smoker by smoking participants, there tended to be differences between the SES groups. Half of the higher SES smoking participants did make such a connection. However it lacked the moral dimension provided by the non-smoking participants. They also tended to distance themselves from the image by identifying their source of information as the media:

'If you took a cross-section of society you would find areas where smoking is going on just as much as ever it did, I mean if you look at it sociologically, I mean, I've stressed that I associate smoking with offices, and that sort of thing, but if you look at a lot of people who work in manual occupations or in semi-skilled jobs, they smoke a lot too'

Participant 13, Smoker, Higher SES male, 40-60 years old

Very few lower SES smoking participants mentioned an association between being working-class and being a smoker. This may well be because they do not wish to identify themselves with these negative associations.

6.3.5 *Margins of Society*

The final 'Other' social group associated with smokers is those on the margins of society. Several participants mentioned 'drug users' in this context, an association which is explored fully in the Addiction chapter. Two other marginalised groups were also identified by a minority of non-smokers. One is the homeless who epitomise the extreme of social deprivation:

'There's a bloke down at London Bridge who I see every morning and evening if I walk that way and he's been there for years, years and years, even since I've been working here and when I get the chance, instead of giving him money which I think he will spend on booze and fags, if I've got a take-away I give him some chips, although I've given him money as well, but he's very dirty, very unwashed, unkempt, he smokes I've seen him smoking roll-ups and stuff. I think all street people smoke; I mean every single one of them'

Participant 26, Non-Smoker, Higher SES male, 20-40 years old

The second group, identified only by higher SES smokers, were 'criminals':

'It's not shown as glamorous in the media at all, or television, you hardly ever see people smoking at all on TV, occasionally police officers interviewing criminals offer them a cigarette, don't they, that's a bit, that's a bit of a message'

Participant 28, Non-Smoker, Higher SES female, 40-60 years old

No smokers at all, in either SES group, identified either the homeless or criminals. Again, these are associations which are unpalatable and from which they would derive no benefit.

In summary, several 'Other' socially marginalised groups were associated with being smokers. Participants from each group (smokers and non-smokers, lower/higher SES) identified images of smokers at the extremes of age. The images were predominantly the embodiment of negative associations; the stereotype of the old ill, addicted, heavy smoker and the young irresponsible teenager who does not think about the future. Higher SES smokers also identified with a more positive image of the young trendy social smoker. Participants also found 'women' smokers to be another salient group; particularly teenage girls and mothers who smoke in front of their children. These images of women smoking often appeared to transgress ideals of femininity. A third 'Other' social group identified with smokers was the working-class or disadvantaged. Connotations include transgressing moral boundaries, misuse of money and lack of responsibility on the part of poor smokers. The frequency with which this association was mentioned was a function of the identity benefits that might be gained: thus higher SES non-smokers were the most vociferous whereas lower SES smokers tended not to mention it at all. Finally, a minority of non-smokers associated smokers with groups on the margins of society, specifically the homeless and criminals, as well as drug-users.

6.4 Results: The experience of social disapproval

Social disapproval can broadly be divided into two categories; indirect, where the smoker is not directly challenged, such as seeing non-smoking signs or being in an environment in which smoking is perceived as being unacceptable, and direct disapproval where the smoker is directly confronted with a comment or action about their smoking behaviour by another person. This section considers how non-smoking participants exhibited social disapproval of smokers and how smoking participants respond. Particular attention is paid to socio-economic differences which indicate a differential attitude to social disapproval perhaps indicative of existing social position.

6.4.1 Non-smokers

No major differences emerged in the perceptions of the social disapproval of smokers by lower and higher SES non-smoking participants, so it is presented together.

Firstly, non-smoking participants identified smokers as part of a minority group whose behaviour is currently thought of as 'anti-social' or 'unacceptable' by most. The anti-smoking sentiment is seen as having intensified in the recent past:

'[Smokers] could see themselves becoming the minority as more and more younger people came into the environment and disproportionately less people smoked as they were coming in, so there's been a complete move away from smoking as being socially acceptable'

Participant 8, Non-Smoker, Lower SES male, 20-40 years old

In this understanding, smokers are not simply a minority group, they are a stigmatised one. Non-smoking participants used terms such as 'outcast', 'persecuted', 'denigrated', 'under-class', 'blacklisted', 'underground' and 'lepers' to refer to their treatment in society:

'I mean, mine and the view that most of my friends is that you are an outcast, it's not socially acceptable and it is very thoughtless to blow smoke on others'

Participant 28, Non-Smoker, Higher SES female, 40-60 years old

Smokers' status as a stigmatised minority is reinforced, in their view, by the segregation of public places into smoking and no-smoking zones. Spatial norms are revealed by the sample over where it is acceptable to smoke. Some of these are places where the actual risk of contamination is very high, such as in enclosed spaces like public transport or in one's personal space. Another area is that around food and in restaurants, which may reflect more a symbolic fear of contamination and feelings of disgust linked to the notion of pollution. Considerable social disapproval is shown to those who transgress these boundaries by smoking within them:

'When we have friends round, as I say, some of them smoke, I won't have them smoking in the living room. It's something that I resent, I won't accept that they can smoke, and they'll respect that and smoke in the garden. In winter they will smoke in the kitchen, I'm not that callous, I won't let them freeze, but I'm not happy with people smoking in my personal space'

Participant 12, Non-Smoker, Lower SES male, 20-40 years old

The extent to which individual non-smokers in the sample were personally tolerant or highly disapproving of smokers varied considerably. However, only a small minority of non-smokers were prepared to show explicit disapproval of smokers by challenging their smoking behaviour. This young female non-smoker, a gym receptionist who liked to socialise with her boyfriend on weekends was prepared, along with her partner, to challenge smokers' behaviour to their face:

'If they are being absent-minded with the cigarette, I would brush it away, if somebody was blowing smoke in my face, I will make an issue of it and turn round and say 'excuse me, do you know what you are doing?' Usually they are quite apologetic, but there have been other cases where they have been like, 'fuck off, I'll blow it where I want to'. So it is a 50/50 split. My boyfriend always gets 'sorry mate' as he's quite a big guy'

Participant 39, Non-Smoker, Lower SES female, 40-60 years old

In terms of behavioural discrimination towards smokers, the most common action was to move away from them or choose non-smoking areas. Some non-smokers said that they found smokers less attractive or would not date a smoker:

'I do tend to judge people. If I see quite an attractive human being, a bloke in particular, and then I see him smoking, that is it, I just think oh gosh, I would not be in the least interested. And it's terrible and it isn't rational'

Participant 27, Non-Smoker, Higher SES female, 40-60 years old

In terms of discrimination in the workplace, the image of office workers huddled in the cold outside office blocks is a highly salient one which is thought to epitomise social disapproval and exclusion:

'Society obviously marginalises smokers because people have to go and stand outside their office block to go and have a cigarette and a lot of public places are now non-smoking'

Participant 9, Non-Smoker, Higher SES female, 20-40 years old

Several non-smoking participants also mentioned that they thought the image of the smoker was in many ways incompatible with a truly professional image. This was because being a smoker might carry connotations of laziness, taking a lot of 'breaks' or potential ill-health. This might therefore count against smokers in the work context, for example, Participant 10 had worked as a supervisor in a previous job which had made him conscious of the 'time-wasting' nature of smoking:

'I think organisations are becoming conscious that if we take someone on who is a smoker, they are more likely to be sick. We did have a group what wanted to go out and have a fag break and the non-smokers didn't. Had that stamped on very quickly in the early years until in the end some temps were dismissed by myself because of the persistent going outside. I just could not afford to create these divisions within the section for non-smokers and smokers'

Participant 10, Non-Smoker, Lower SES male, 20-40 years old

Although non-smoking participants perceived there to be many disadvantages in terms of social disapproval for being a smoker, they also perceived some benefits. The main one they identified was to be a member of the smokers' 'club'. They thought this would afford opportunities for social bonding, such as networking at work, or meeting people in a social context by asking for a light:

'It's a little bit like a club of their own, cos if you walk past offices cos they can't smoke in the building, all the smokers are like in a little group, and I think in a way that might be quite nice cos you've got an easy bond with a group of people, a little social group if you like'

Participant 14, Non-Smoker Higher SES male, 40-60 years old

However, non-smoking participants thought that in general holding a smoking identity would be the basis for considerable social disapproval. Indeed, to prove this point, several non-smoking participants admitted that they personally thought less of smokers simply on the basis of their status as smokers alone:

'I feel like you are on a class level a better type of person if you don't smoke, because it is just so there, it is just so in your face, like if you go to a restaurant you have to be separated, segregated from other people. I feel they are kind of judged, and if they were coming to a person like me who really is against

smoking, unfortunately before they have even opened their mouths, that's a strike against them.'

Participant 39, Non-Smoker, Lower SES female, 40-60 years old

6.4.2 Smokers

There were some differences in the perception of social disapproval for smokers by lower and higher SES participants, so these are highlighted where appropriate.

Both higher and lower SES smokers in the sample agreed with the non-smokers that smoking is considered in the main socially 'unacceptable' and that the resultant disapproval has intensified in the last twenty years or so:

'Years ago, people who didn't smoke weren't [waves hands about]. It didn't seem to offend them, whereas now it does and that annoys us because when we were smoking years ago, there was no problem about smoking, people didn't act like they were choking. I mean, maybe they are, but it has changed, people's attitudes have changed'

Participant 19, Smoker, Lower SES female, 20-40 years old

They also see the spatial segregation of smokers into smoking and non-smoking areas in public as a manifestation of the changed status of the smoker:

'I think it is generally scorned upon, simply by the factor all the buildings are non-smoking and you don't even have smoking rooms any more, you have to go outside and not on trains, not allowed to smoke anywhere except outside'

Participant 5, Smoker, Higher SES male, 20-40 years old

The experience of social disapproval amongst higher SES smoking participants was as part of a very small and ever shrinking minority group within their social milieu:

'Ten years ago we would go out to dinner and we would find that of the group of people that had been invited, probably a third smoked and now hardly you find any, only one or two people that smoke. It's quite unusual to go out for dinner to find that there's more than one other person that smokes, to be honest.'

Participant 37, Smoker, Higher SES female, 40-60 years old

Thus smoking is for them something that often has to be hidden. For example, many higher SES smokers tended to perceive their families are anti-smoking and therefore

concealed their smoking from them, a tacit acceptance of this disapproval. However, few higher SES smokers reported being directly challenged about smoking by their family:

'My family doesn't smoke at all, neither of my parents smoke...my brother smokes, I smoke, I'm pretty sure my parents know we both do, but we don't smoke in the house, not even the garden, out of bounds or anything. They wouldn't want to see us smoking at all and they never have. It's something they know we do but don't want to see it, they don't want to know about it, don't even want to admit it to themselves'

Participant 1, Smoker, Higher SES female, 20-40 years old

The majority of higher SES smokers did not smoke around colleagues in a work environment, being in no-smoking offices. Few perceived there to be many problems with smoking at work:

'We used to have a smoking room, to be honest. I'm sure they turned the air conditioning off there so that it was so horrible that nobody even went in there, so I don't particularly mind smoking outside to be honest'

Participant 37, Smoker, Higher SES female, 40-60 years old

Higher SES smokers were concerned, however, about people's perceptions of them for being a smoker. They were aware that their smoking status could have negative connotations which were undesirable:

'You do get stereotyped as a smoker...I think people automatically link it to the whole of what you do, job-wise, possibly the type of friends you have, the type of social, what you do socially. They just automatically make certain associations. If you smoke, I think people see you as being, not off the straight and narrow, but I do think that people class you differently, they kind of assume it's a bit naughty and I think it has a kind of selfish aspect'

Participant 2, Smoker, Higher SES 20-40 years old

Despite this, they tended not to label themselves or smokers as a whole in stigmatising terms such as 'outcast'. Only a few mentioned that they might be 'demonised' or considered 'a bad person' for smoking. This may be because they wanted to distance themselves from being a member of an out-group.

The experience of social disapproval for the lower SES smokers in this sample was somewhat different: in general they reported experiencing much greater social disapproval than the higher SES smokers. This is interesting in the light of the fact that the lower SES participants often reported being in large minority or even majority in their own social milieu. They felt part of the 'social mix' or a 'balance' of smokers and non-smokers in a way that the higher SES smokers did not:

'You are looked on as anti-social, but amongst my closest friends, no, that's fine. The majority of my friends don't smoke, but their partners do smoke, so there's that balance perhaps'

Participant 31, Smoker, Lower SES male, 40-60 years old

Despite being part of a statistically larger group, lower SES smokers detailed many more instances of experiencing indirect social disapproval:

'Do you know I've been places, H, and I've lit up a cigarette and people look at you like you're, you're nobody, 'do you have to puff your smoke over me?' This is what you get'

Participant 20, Smoker, Lower SES female, 40-60 years old

Furthermore, although lower SES participants reported having extended families many of whom smoked, they also appeared to experience greater disapproval from the non-smoking family members:

'My mum and dad smoke, my sister, my two sisters and brother smoke, but my sister who has got three children, two of whom are teenagers don't smoke and they are very anti-smoking and they are always pressuring my sister to stop smoking and my sons are too, so it seems like the generation from us are totally different with smoking, they totally and utterly hate it'

Participant 19, Smoker, Lower SES female, 20-40 years old

They also tended to have experienced more direct challenges to their smoking behaviour compared with the higher SES smokers. This relatively young (39 years old) smoking mother, who worked as a part-time cleaner, had had a hysterectomy recently in hospital which had brought her into contact with this type of social disapproval:

'After I had my hysterectomy, I was bringing my catheter bag and my drips and my morphine to walk half a mile to get outside a side door to have a cigarette and this surgeon came in the morning, me and a few other people had been standing in the doorway where it was strictly you couldn't smoke, but I thought it's early and no-one will notice and the surgeon came in and the way he spoke to me and looked at me, with disgust that I was smoking and said 'you shouldn't be smoking here' and there I was, I had drips hanging out of me, and I could barely stand up, but the look of disgust, you know, one as a doctor, how can you be smoking when you are in such a bad state and two, you are disobeying the rules'

Participant 19, Smoker, Lower SES female, 20-40 years old

Many lower SES smoking participants also detailed problems at work with their smoking, usually because they smoked or wanted to smoke in designated non-smoking environments. Several had been caught or disciplined as a result:

'It's against the contract to smoke, but she caught me smoking, didn't she, so I got reported for it. But they're really bashing down on the smoking thing now, I keep getting asked at work 'are you smoking in public?' I didn't realise you were not allowed to smoke, you are not allowed to smoke at all, you know. It's ok if you hide somewhere – basically if you keep a low profile'

Participant 7, Smoker, Lower SES male, 20-40 years old

Despite these experiences of considerable social disapproval, there was a tendency for lower SES smoking participants to be less concerned about the impression being a smoker gave to others than the higher SES smokers. They did tend, however, to label themselves as part of an 'outcast' or stigmatised group in a way that the higher SES smoking participants did not. This suggests some acceptance of their membership of an 'out-group':

'It's kind of like you are an outcast if you are a smoker, you know'

Participant 22, Lower SES female, 20-40 years old

In summary, from the non-smokers' perspective, smokers are clearly identified as part of a stigmatised minority group. Although personal tolerance on the part of individual participants varied, there was consensus that certain spatial norms should be followed by smokers. Those that transgressed them were subject to considerable indirect social disapproval, though rarely directly challenged. In terms of behavioural discrimination,

the non-smokers reported drawing spatial boundaries between themselves and smokers. The image of a smoker was also deemed incompatible with being attractive in a social context and professional in a work context by some. The benefit of being part of the smokers club was therefore outweighed, in the non-smokers' viewpoint, by the disadvantages of the negative connotations.

Smokers in this sample were also aware of their status as members of a club which engages in socially 'unacceptable' behaviour. The perceptions of social disapproval differed, however, between lower and higher SES smoking participants. Higher SES smokers tended to report being part of a smaller minority group and their smoking was often hidden from families and in a work context. Despite being concerned about the negative connotations their smoking identities might bring, they tended not to label themselves as 'outcasts', perhaps to distance themselves from being seen as members of an 'out-group'. In contrast, although lower SES smoking participants were often with larger groups of smokers in their own social milieu, they tended to have experienced greater and more direct social disapproval. They also identified smokers as part of an 'outcast' group, perhaps indicating acceptance of this status.

6.5 Results: Coping with disapproval

Despite differing experiences and perceptions of social disapproval, the strategies used by both lower and higher SES smokers in the sample were similar.

One way that the smokers in this sample coped with social disapproval was to observe the social norms around smoking. They termed this 'respect' for non-smokers which constituted deference to the non-smoking norm in many situations. As discussed in the previous section, this was mainly in contexts in which the fear of contamination was high such as around food or around 'innocent others' such as children:

'I can't think of anybody who is a non-smoker who would expect you to be smoking in their home. It's almost an unwritten law that you will go outside. I mean sometimes they will say just have it in the kitchen, but keep the door closed. Also if friends come round with kids, for instance, I wouldn't smoke in the room they are in, whereas as I say, in the past you would have done. Now it is very much the case that you are the problem'

Participant 18, Smoker, Higher SES male, 40-60 years old

An extension of this strategy for some smokers was to align themselves more fully with the non-smokers and not to identify too strongly with their own group (dis-identification). For example, many smokers claimed they also disliked smoking in public places. This served to draw a boundary between 'other' smokers who are deemed 'anti-social' and themselves. By showing themselves to be 'respectful' rather than 'selfish', they distance themselves effectively from this negative aspect of the smoking identity:

'Even though I smoke, I never smoke in restaurants and I find it extremely arrogant and insensitive of people...so although I smoke, I share some feelings about people who smoke anti-socially, but that's probably because I make a distinction for my own, my own pride, in the sense that I regard myself as not being an anti-social smoker'

Participant 13, Smoker, Higher SES male, 40-60 years old

Another strategy was to contest and challenge these norms. This rejection usually took the form of privately rejecting the thinking behind discrimination against smokers. Such discrimination was considered 'unjust' and 'unfair' with the perception that smoking is singled out amongst undesirable lifestyle behaviours in a unique way:

'You are having a cigarette and Joe Public will walk past and feel like they can happily give you their opinion on you and you think, well, I don't come up to you and say 'you're fat and you smell and you should maybe have some better personal hygiene and lose some weight' but smoking is something you can take a pop at anybody who has a cigarette and it is perfectly legitimate'

Participant 37, Smoker, Higher SES female, 40-60 years old

Very few smokers actually reported challenging non-smokers in the face of social disapproval in the manner of Participant 19, who responded to the social disapproval expressed by a doctor in the hospital following her hysterectomy as follows:

'And I got aggressive with him, I wasn't going to be spoken down to as a smoker and it was 'if you hadn't closed down the only smoking room in the while of the hospital, we wouldn't be shivering trying to have a cigarette with ill-health. You can't expect us, because we have just had a major operation, to not want a cigarette or need a cigarette'

Participant 19, Smoker, Lower SES female, 20-40 years old

Another strategy to reduce stigmatisation is to find a dimension on which the stigmatised or out-group compare favourably (social creativity). In these interviews, the smokers appeared to do this by identifying themselves as 'sociable' and using this as the basis of positive social comparisons:

'We're more sociable, there's no doubt about that. We know how to enjoy ourselves. Down the pub, that's a smokers' paradise'

Participant 16, Non-Smoker, Lower SES male, 20-40 years old

Several smoking participants also compared themselves favourably to non-smokers on the dimension of risk-taking and 'living life to the full'. In this mind-set, being 'real' entailed allowing oneself to have many different experiences, including smoking. Positive social comparisons were made between the smokers who know how to live life and the non-smokers who as a group are deemed 'boring', 'conventional-thinking', on the 'straight and narrow', 'clean-cut', 'anal' and having an inability to show weakness:

'It's difficult to explain, but you almost feel like people are being smug and complacent, they're fine, they don't have to smoke, they don't need to smoke, maybe they are too controlled...if you smoke it's actually showing you are human, that's how I feel. That you do know your weaknesses, that you have to give in to them sometimes...I'm not comfortable with people who don't smoke or drink, I sort of think, hand on, how have they got to be adults without tasting the forbidden fruit at some point, are they real, do they live in the real world?'

Participant 13, Smoker, Higher SES male, 40-60 years old

A final strategy for mitigating social disapproval was to change one's status from a minority to majority group by hanging out with other smokers. Smokers reported this functioned to shield them from negative social disapproval and validated their behaviour, as well as being enjoyable and bonding in its own right:

'It's a relief when you are in this group of people and you suddenly see somebody who actually has got a cigarette and it's like 'oh shall we go outside and have a cigarette'. It's almost like a social bond. And it's an extraordinary thing because it's nothing more other than a shared addiction to a poisonous substance, but it seems more than that, and I think it explains why people often do find it quite difficult to give up smoking even when they are fully aware of the medical damage that it is doing'

Participant 13, Smoker, Higher SES male, 40-60 years old

However, higher SES smoking participants tended to feel that these bonding opportunities were no longer there to the same extent as their numbers were falling below a critical level in many contexts. This 43 year old male product manager felt excluded by being a smoker in his current company:

'One time, we had one of the Directors who smoked, and that was quite good for the gossip. It used to be a way of you interacting with people in other divisions that you wouldn't normally meet, so that was quite a good networking opportunity, but less and less people smoke now, so there is still an networking opportunity but not at the same level. I don't think any of the Directors smoke at all now'

Participant 37, Smoker, Higher SES female, 40-60 years old

This was not so much the case for lower SES smokers who tended to be part of a social group where smoking was still relatively normative. The concern for some of them was that being part of a group of smokers was holding them back from quitting. For example, this receptionist liked to relax or 'chill' with her sister on the weekend with a cigarette:

'It's like you've got something in common with the smokers, I mean if you go out with smokers, most of the people I do tend to go out with do tend to be smokers. It's like enjoyment together, I enjoy it. Like I say, I smoke with my sister and we spend a lot of time together and when we are together we do tend to smoke quite a lot and drink. Obviously if you are trying to give up smoking, you've got to do something about it, you've got to change your circle to a certain extent til you think you've overcome the problem'

Participant 21, Smoker, Lower SES female, 40-60 years old

In summary, there were few differences between higher and lower SES smokers in terms of the coping strategies they used in the face of social disapproval. Smokers from all social groups in the sample tended to show acceptance of social smoking norms.

This allowed them to distance themselves from some of the negative aspects of smoking identities by identifying themselves as 'respectful' smokers rather than 'selfish' ones. Although some smokers did privately contest these norms by asserting the rights of the smokers, they rarely did so in public to non-smokers. Many smokers also used a social creativity strategy of finding dimensions on which they positively compared. In particular, being sociable and living life to the full were identified as positive strengths. Finally, smokers also mitigated social disapproval by mixing with other smokers and emphasising the bonding opportunities. However, higher SES smokers thought that their opportunities as an extreme minority to do this were increasingly diminishing, whereas some lower SES smokers pointed out that this bonding, though facilitative on one level by allowing them to relax in the company of other smokers, made it harder for them to quit.

6.6 Discussion

6.6.1 *To what extent are smokers stigmatised?*

Very little existing research has comprehensively considered the stigmatisation of smoking identities in the UK. The first thing to consider, therefore, is whether smokers are indeed 'stigmatised' in line with theoretical literature outlined in Chapter Three (Goffman, 1963; Jones et al, 1984; Crocker et al., 1998; and Stangor & Crandall, 2000).

One of the dimensions of stigma is the existence of a 'mark' by which the stigmatised person, or 'target', is identified (Jones et al, 1984; Crocker et al., 1998). Crocker *et al.*, have argued that 'visibility' of this mark, or its counterpart 'concealability' (Jones et al., 1984), is a particularly important dimension of stigmatisation. This is because it determines how the stigmatiser (or perceiver) reacts and how the target responds to this reaction; highly stigmatising marks often provoke considerable concealment. On initial consideration, it may appear being a smoker is a relatively concealable identity.

Someone does not have to smoke in a given situation and thus may avoid being identified as bearing a mark. However, the results here show that smokers and non-smokers do use stigmatising markers to identify who is a smoker, namely through smell and a negative aesthetic appearance.

The marks of stigma are not merely assessed at a cognitive level but are subjectively assessed in emotional or affective terms (Jones et al., 1984). This was visible here in the discourse of the non-smoking participants concerning the aesthetics of smokers which was full of powerful negative emotions. The highly salient smell of smoking, for example, was described as a 'reek', 'stink', or 'pong', provoking repulsion, dislike, irritation, disgust and sickness in the perceiver. An initial, perhaps unconscious, reaction to stigmatising marks does not have to result in continuing negative feeling. For example, a disability may also elicit sympathy (Dovidio, Major and Crocker, 2000). However, this is arguably not the case here. The results of the section on the social disapproval of smoking revealed that displaying dislike or disgust these stigmatising marks was considered socially legitimate in a way that it would not for a disability. This disgust towards the negative aesthetic of the smoker suggests, using Goffman's classic typology of stigma (1967), that smoking currently is not only considered as a 'blemish of individual character' but also an 'abomination of the body'.

The markers of smoking are also clearly associated in this sample with an undesirable set of metaphors concerning pollution and contamination. Smoking, for both smoking and non-smoking participants was conceptualised as a polluting habit, which is 'dirty' and 'filthy'. Smoke was understood to be a substance which is 'toxic' or 'poisonous'. This has two negative implications for smokers which may contribute to their stigmatisation. Firstly, by engaging in a polluting habit, their own identities are metaphorically 'dirtied' by this association and they are perceived by many non-

smokers as being unclean or lacking in self-care. Their identities are thus both visibly and metaphorically 'spoiled' (Goffman, 1967) by smoke.

Secondly, the use of the metaphor of pollution and contamination implies a threat to others. This dimension of stigma is often referred to as 'peril' (Jones et al., 1984) or 'threat' (Stangor and Crandall, 2000). It refers to the perceived danger that the stigmatised group represents to others, based on a universal motivation to avoid danger, coupled with a perception of threatening characteristics (often exaggerated) which are socially shared (Stangor and Crandall, 2000). The pollution discourse revealed here represents smokers as a 'health threat' to others who they 'pollute' with their smoke.

The extent to which participants in this sample perceived smokers to represent a health threat varied considerably. Higher SES smoking participants tended to minimise the risk to others and compare their polluting behaviour favourably with that of other polluters such as car drivers. This functioned to distance them from an undesirable 'risky' social identity. On the other hand, lower SES smoking participants tended to identify themselves clearly as a risk to others. Several even stated that they thought that others were more at risk than themselves from their smoking. This acceptance of their status as a 'danger' to others may indicate a converse internalisation of the 'spoiled' smoking identity.

Although any given threat may be real and tangible, it is also be filtered through moral and symbolic perceptions (Stangor and Crandall, 2000). These results suggest smokers are certainly perceived as a moral threat. For example, smokers are perceived by non-smoking participants to represent a risk to 'innocent others' such as children, an act which is bound up with moral issues concerning poverty and a lack of social responsibility for which they are blamed. Those who had committed moral transgressions, such as the lower SES women who had smoked whilst pregnant, were at

pains to emphasise their ignorance of the risks in the past and their intention never to do so again in the future. In doing so, they were acknowledging the social and moral transgression which this represented.

These threats are also symbolically constructed. Douglas, in 'Purity and Danger' points to the importance of purity laws within societies in which subjects are ascribed as 'dirty' and 'clean' as a way of controlling the physical and social body (Douglas, 1966). The idea of 'contamination' is also linked to notions of 'infection' or 'contagion' which have often been at the heart of stigmatised health threats (Crandall and Moriarty, 1995). The understanding of smoking as pollution in this sample has at its heart the notion that smokers are contaminators who invade the personal space and physical bodies of others. As such, they are perceived as highly threatening and therefore legitimate targets for stigmatisation.

As Douglas has argued, those who are labelled 'dirty' threaten not only themselves, but the body politic. As such, they are the subject of attempts at control and restriction (Douglas, 1966). This is very much in evidence in the spatial norms revealed by participants concerning where it is and is not appropriate to smoke. Numerous such unwritten rules were uncovered, particularly around areas of concern of contamination, namely personal space, confined spaces and food. What is interesting is that the non-smoking participants as well as smoking participants identified and deferred to these norms, at least in public even if they privately contested them. This may reflect an acceptance by smokers of their identity as modern-day polluters who have to be contained. Furthermore, many smokers claimed they identified with non-smokers in their dislike for the polluting aspect of smoking. This dis-identification functioned to distance them from the 'selfish' smoker identity and mark them as 'respectful' and thus more socially acceptable smokers.

Another way in which stigmatised groups may symbolically represent a 'threat' is by challenging certain social values which are socio-culturally important (Stangor and Crandall, 2000). Many commentators have argued that the key Western value underlying stigma is control (Crocker et al., 1998; Stangor and Crandall, 2000). This refers to the extent to which the person is held responsible for the stigma, also termed the 'origins of the mark' (Jones et al., 1987). Crandall and Moriarty (1995) argue that in the case of stigmatised health threats, personal responsibility for the health threat may serve as a signal or proxy for instrumental threat; the person's lack of control over the threat exacerbates perceptions of its severity. People with controllable stigmas are thus likely to face more rejection than those with uncontrollable stigmas. In the following two chapters, on Health and Addiction, it will be argued that smoking is stigmatised because it embodies a lack of control. The results that will be presented will show that this tended to differ between lower and higher SES smoking participants. Higher SES smokers tended to emphasise their control over their smoking, whereas lower SES smokers often accepted its uncontrollability. It seems plausible that as a result of this, the lower SES smokers are more likely to attract a blaming, stigmatising, social response.

A final dimension of stigma to consider is the extent to which the stigma disrupts social interaction (Jones et al., 1984). The overall results in this chapter indicate that social disapproval of smokers is relatively strong, however, this does not always translate into behavioural discrimination. Much of the social disapproval was implicit, such as no-smoking signs and areas, 'significant looks' and the general awareness that smoking is considered 'unacceptable'. These results also suggest that lower SES smokers found themselves subject to greater social disapproval than the higher SES smokers. At first sight, this finding seems counter-intuitive as it might be thought the higher smoking

rates in the lower SES groups would establish smoking as normative and thus less likely to be stigmatised.

However, there are several reasons why the lower SES smoking participants might have reported such significant social disapproval. Firstly, although in their own social milieu, smoking may be normative, it is not in other social situations. Thus as lower SES smokers move into a wider social context, such as in public places or work, they may experience their normative behaviour becoming stigmatised. Several lower SES smoking participants had been disciplined at work for smoking, for example. Secondly, working-class smokers may be more addicted to nicotine (Bennett et al., 1995). They may be more likely, therefore, to feel the need to smoke in a wider number of social situations and thus to be stigmatised as a result.

Lower SES smokers may also attract more disapproval from lower SES non-smokers. There is no indication from these results that lower SES smoking participants were more tolerant of the smokers in their social milieu. This may be because at an identity level, lower SES non-smokers have had to position themselves clearly in a social group where smoking is normative. They are therefore motivated to draw boundaries between themselves and the smokers by displaying disapproval and blame. Finally, the lower SES smoking participants appear to have internalised many aspects of the stigmatised smoking identity, for example, labelling themselves as 'outcasts'. Reporting high levels of social disapproval, therefore, may provide 'evidence' to others of the stigmatisation they face.

The priority of higher SES smoking participants in the face of social disapproval tended to be 'concealability' (Jones et al., 1984). They reported spending considerable time and energy, for example, concealing the 'marker' of smoke from family, friends or work-colleagues. Higher SES smoking participants were often in contexts in which they were

an extremely small minority. As such, they would then conform to the prevailing middle-class no-smoking norm. The ability to conform to the no-smoking rule, either because they are less physiologically addicted to nicotine or because it is simply normative for them, gives higher SES smokers much greater social flexibility. Finally, higher SES smokers tended not to portray themselves as stigmatised compared with the lower SES smokers. They did not associate themselves personally with the negative aesthetic of the smoker, for example, and did not tend to use labels such as 'outcasts'. This suggests they do not wish to identify themselves with a 'stigmatised', and thus a socially less dominant, group.

It is important to note that according to this sample, being a smoker can promote social interaction as well as disrupt it. Non-smoking participants, particularly higher SES non-smokers, perceived there to be considerable social benefits from being a smoker in terms of bonding, shared experiences and opportunities for new social interactions, for example, through offering cigarettes or going into 'excluded' zones together to smoke. Lower SES smokers also offered an understanding of smoking as a relaxing, socially enhancing experience. However, the higher SES smokers themselves, who are perceived by their non-smoking counterparts to enjoy such bonding opportunities, did not wholeheartedly agree. They argued that there are now so few smokers in their social milieu, the benefit of having minority status is rapidly diminishing. This is particularly in the workplace as the opportunity to cross the managerial divide or network through smoking has considerably lessened as middle-class smokers become scarcer.

Being a smoker therefore appears to embody a combination of tangible and symbolic threat in the current socio-cultural context of the UK. Indeed, the two are so intertwined, it is impossible to view them apart. All attempts to actually calculate the realistic threat of passive smoking to others are viewed through the symbolic prism of a threat to purity

and the transgression of moral values, particularly not 'polluting' others, not harming 'innocents' and not being 'out of control'. As such, following Goffman, smokers can be argued to have a 'soiled' as well as a 'spoiled' identity, which leads them to experience considerable social disapproval and stigmatisation.

It is worth noting, however, that the experience of this sample may not be typical of other lower and higher SES smokers. For example, some of the lower SES sample was drawn from the Smokers' Clinic although they did not attend treatment. It might be that their experiences of greater social disapproval may have prompted them to seek help. Similarly, the internalisation of their understanding of themselves as a 'risk' to others may reflect an acceptance of a medicalized model not shared by all other lower SES smokers. It is also worth noting that non-smoking participants may have been motivated to respond to the invitation to interview by an anti-smoking agenda more than the general population of non-smokers, although their personal tolerance towards smokers and smoking did appear to range widely rather than representing an 'en masse' anti-smoking brigade.

6.6.2 *Being a smoker and being 'Other'; the interaction of social stigmas*

Theoretical accounts of the dimensions of stigma have tended to neglect the ideological consequences for the target and perceiver. As Schur (1980) reminds us, stigmatisation is not merely about inter-personal and inter-group interactions, it constitutes an opportunity for social control. Crawford's thesis (1994), developed in the context of HIV/AIDS, argues that constructing middle-class social identity on the foundation of health is fundamentally socially divisive. He argues that our sense that we are constantly 'at risk' from death, disease and illness makes us feel permanently vulnerable to health risks. The consequence of this for the middle-classes is not merely a strong desire to identify oneself and one's social group as 'healthy', but to project disease,

illness and risky behaviour onto other already stigmatised 'Other' groups. In the case of HIV/AIDS, these are groups such as gay people, foreigners, sex workers or drug users (also see Joffe, 1995; 1996).

The results presented here indicate that a parallel type of projection may occur in the context of smoking identities. In this sample, being a smoker was associated with a set of already stigmatised or 'Other' groups such as those at the extremes of age (old/young), female, working-class/disadvantaged or on the margins of society. These stigmas then appear to interact and contribute to further stigmatisation.

It might be argued that such identification of 'Other' groups as smokers is not necessarily a 'projection', more an association. For example, epidemiological evidence shows that greater numbers of working-class and young people do indeed smoke (e.g. Lader and Meltzer, 2004). However, this is not always the case. To take an example, a significant proportion of participants thought that young girls and women smoke more than young boys and men. In fact, the epidemiological evidence is that men still smoke more than women (28% to 26%) do and that smoking initiation rates are roughly equal amongst genders (Lader and Meltzer, 2004). Yet despite this, many participants reported noticing higher numbers of women and young girls smoking 'everywhere'.

Smoking mothers also have a high salience for participants. The discourse surrounding them shows they are often demonised for 'harming their children' whereas there is no equivalent moral censure for smoking fathers, even though when not pregnant, the risks of either parent smoking is the same for the child. It is suggested here that at a subliminal level, females smoking still in some ways transgresses wider socio-cultural ideals of femininity as indeed it did historically when large numbers of women took up smoking during the War (Hilton, 2000). Smoking women who do not 'fit' with the predominantly negative smoking identity, such as those who are young, pretty or

professional, are seen as incongruous in some way; conversely women who are already stigmatised, such as poor single mothers, experience compounded stigmatisation by being identified as 'immoral' through their smoking.

Another stigmatised social grouping which is strongly associated with smoking are those with 'age stigmas', namely the 'too old' and the 'too young' (Zebrowitz and Montepare, 2000). The results here suggest that smoking identities interact with the stereotypes of the old and young to enhance what is already identified as negative about them. Thus, for example, the smoking of the 'too young' highlights already existing features of their stereotypes such as their inexperience, weakness in terms of peer pressure, their lack of individuality and their lack of foresight or responsibility. The smoking of the 'too old' highlights features of their stereotypes such as their loss of control, their poverty, their ill-health and their symbolic proximity to death. For middle-class young smokers in particular, the 'old poor smoker' represents a 'horror' figure who embodies everything that is negative about smoking. Old and young are not equally stigmatised for smoking, however. The old are excused moral culpability for smoking on the grounds that they did not 'know better' and often elicit pity, whereas young smokers are more likely to be held responsible and blamed for their actions.

Another group associated with smokers by this sample was the 'working-class'. As Chapter One showed, there is a strong linear association between all markers of social disadvantage and being a smoker (e.g.; Marsh and McKay, 1994; Jarvis and Wardle, 1999). The results here suggest that this link has permeated the consciousness of lay people. Smoking is arguably becoming a 'marker' of lower social status for many. There were clear group trends in the discourse surrounding the working class smoker. The group who tended to frequently and most strongly make this association were the higher SES non-smoking participants. Their discourse was profoundly negative,

containing a constellation of negative associations such as lack of education, lower intelligence, the transgression of moral boundaries such as harming 'innocent others', the misuse of money, economic inactivity and not taking responsibility. Their image of the 'poor smoker' also often incorporated other stigmatised groups, epitomised by the young, single, working-class mother who smokes. This multiplication of stigma serves to intensify the blame and judgement. This 'poor smoker' discourse arguably represents identity work on the part of the higher SES smokers. As Crawford has argued, identifying 'Others' as engaging in risky, unhealthy behaviours draws boundaries between 'Us' and 'Them' which fortifies their existing status and values.

The discourse surrounding the 'poor smoker' was somewhat different amongst the other groups in the sample. Several lower SES non-smoking participants did make a link between smoking and social disadvantage. However, they tended to identify 'Other' more disadvantaged groups than themselves as likely to have high smoking rates, such as the unemployed. In terms of identity work, this constitutes the 'Other' finding 'an-Other' to identify as the 'risky' group. The strategy of the higher SES smokers was somewhat different. Several higher SES smokers also made a link between smoking and class. However, they often gave the source of the information as the media rather than their own social milieu, thereby distancing themselves from this image. They also lacked a moral dimension to the discourse. Finally, very few lower SES smokers in this sample mentioned the 'poor smoker' phenomenon. This may well be because they do not wish to associate themselves, as part of working-class culture, with the negative associations of belonging to a multiply stigmatised group.

In conclusion, these results suggest that for higher SES non-smokers in particular, smoking functions as a 'marker', not merely of poverty or disadvantage, but symbolically, of social and moral transgression. Thus images such as the 'smoking

single mum' or the 'common young girl' are highly salient to them as the embodiment of devalued social identity. For those who hold these multiple 'Other' identities, the social consequences are likely to be increased stigmatisation.

6.6.3 The institutional and symbolic contexts of the stigmatisation of smokers

The increasing stigmatisation of smokers as a group has not take place in a vacuum, but within a dynamic social context. This has included macro-social 'organizational' influences such as the media and institutional attitudes. It is argued here that the attitude of government towards promoting individual lifestyle change (Petersen and Lupton, 1996), and their symbolic portrayal of smokers in particular, is helping create the socio-cultural context in which the stigmatisation of smokers is occurring. For example, the most recent 'Ugly Smoker' campaign by the Health Education Authority (March 2005) plays exactly on the type of stigmatising marks and negative aesthetic discussed in this chapter (www.uglysmoker.info). With slogans such as 'Smoking makes your teeth minging' and 'You smoke, you stink', its articulated aim is to target young women's concerns about attractiveness to the opposite sex; in other words, to motivate them to avoid the type of negative social identity revealed in this thesis. A complementary campaign for young men targets their concerns about virility, using fear of social embarrassment as a basis for motivating quitting.

It could be argued that the HEA is simply reflecting the negative social identities of the type displayed in these results. However, this is disingenuous: it is unthinkable that any other form of health behaviour would receive the same treatment by a national governmental campaign; 'obese people smell' or 'you are fat, you are unattractive' are unlikely to become slogans for the campaign against obesity. There does not appear to be political correctness surrounding the stigmatisation of smokers at either the political

level or amongst lay people (as the results of this chapter suggests). Indeed it could be argued to be mutually reinforcing.

However, stigmatisation of smokers may be functional if the goal is to reduce overall smoking rates at a public health level. To a certain extent, all health messages rely on the audience having a certain horror or fear of the object as a precondition of behaviour change: one wants to avoid having it (a disease) or being it (a smoker). This is the thinking behind the 'Ugly Smoker' HEA campaign, that young people will be motivated to avoid such a negative social identity. It has been shown in the United States that on both a state and an individual level that an unfavourable smoking climate encourages quit rates (Kim and Shanahan, 2003).

However, it is not clear that stigmatisation is an equally motivating force amongst socio-economic groups. The results here suggest that lower SES smokers may well have experienced greater and more direct stigmatisation than higher SES smokers in recent years, at least in certain social contexts, yet smoking rates in these groups are as high as ever. There are many reasons why this might be the case; one might point to the perceptions of lack of self-efficacy (Chamberlain and O'Neill, 1998), the functional/structural disadvantage (Graham, 1994) or the higher rates of physiological addiction (Jarvis and Wardle, 1998) in these groups. It is also worth pointing out that if a group is already stigmatised, such as poor single mothers, then they may be less susceptible to being motivated to quit through stigmatisation in the first place: smoking may simply be one more dimension on which they fail to meet the dominant moral or social standard. The awareness that others do not value them or their behaviour may simply be internalised rather than translated into behaviour change.

Whether or not the stigmatisation of smokers changes their behaviour, it is likely to increase in the short to medium term. It is arguable that the key driver of this

stigmatisation process has been the successful re-characterisation of passive smoking as a (public) health issue by the anti-smoking lobby. Numerous studies have recently been widely reported in the media which claim that passive smoking is risky to the health of non-smokers. For example, James Repace, a US passive smoking researcher estimates that 1000 non-smokers die in the UK each year from inhaling smoke passively (Repace, Jinot, Bayard *et al.*, 1998). Other studies have highlighted the risks for bar staff (Jarvis, 2001) and those that live with smokers. That passive smoking puts non-smokers at risk has become accepted remarkably quickly given that the evidence is somewhat equivocal. Many of the articles are simply projection studies with models which often contain suppositions that can easily be challenged. For example, bar staff rarely work for 40 years in a bar, so the calculation of their risk is often inaccurate and does not take account of the transitory nature of the work. Far fewer studies have been published which show little or no association, though one controversial study which tracked the partners of smokers for forty years found that there was no higher risk for them for heart disease or lung cancer (Enstrom and Kabat, 2003). Even well-respected, pro-smoking cessation scientists in this field agree that the evidence is not water-tight and has been subject to exaggeration (Jarvis, 2004, personal communication). However, at a symbolic level, the message that is communicated is that smokers (as a entity) represent a 'peril' not just to themselves, but to others and others must be protected from their pollution at all time.

The political agenda, which has driven these studies, has been to push for a ban on smoking in public places in England, in line with those that have already occurred in Ireland, Italy and other European countries. It has been successful: a ban on smoking in public places in England is due to come into effect in July 1st 2007. The overall effect of this re-characterisation of passive smoking as a public health issue has been to heighten non-smokers sense that they are in personal danger from smokers' behaviour.

The results here show that this is certainly reflected in lay people's conceptualisations. Passive smoking was moving up the political agenda at the time that these interviews were conducted (2002) and has been at the forefront ever since. It is likely that sense of 'peril' smoking evokes, at a symbolic as much as actual level, and thus the stigmatisation of the group responsible for such danger, will increase further as a result.

6.7 Conclusion

As Stangor and Crandall (2000) have persuasively argued, the basis of stigma is threat which is both material and symbolic. It has become clear from the preceding discussion that smoking scores relatively highly on both aspects. Smoking is understood, for the majority of participants in this sample, as a tangible, 'real' health threat, both to the smokers themselves who embody 'unhealthiness' and to others through passive smoking. This threat is also symbolically understood through wider socio-cultural beliefs and values. Smokers are seen as transgressing many boundaries, particularly those relating to moral injunctions such as 'not to harm others', particularly 'innocents', and values such as being 'in control'. They also transgress modern-day Western purity laws concerning contamination and pollution. It is arguable that this material and symbolic contamination of both self and others accounts for the distinctive place smoking now occupies amongst the behavioural stigmas. The evidence for the stigmatisation of smokers also comes from the pairing of smoking with 'Other' social groups, namely the old and young, women, the working-class and those on the margins of society. This may create an interaction effect; the multiple stigmatisations augment the strength of the negative associations.

For different social groups, this stigmatising discourse creates different opportunities or problems. For the socially dominant non-smoking majority, particularly those who are middle-class, this boundary-drawing may serve to enhance their status as responsible,

healthy, 'worthy' members of society. Smokers, on the other hand, have to manage their identity as modern-day 'polluters'. Those from different class groups may do so differently. The higher SES smoking participants in this sample tended to distance themselves from the socially stigmatised smoking identity and challenged their status as 'outcasts'. Lower SES smoking participants showed some evidence of internalisation of this stigmatised identity. This is problematic as it suggests that the current emphasis in UK health campaigns, focusing on the negative aesthetic of the smoker and re-characterising passive smoking as high risk, may not produce higher quit rates in target groups such as the 'poor smoker'. Although increased social disapproval and stigmatisation may be motivating for higher SES smokers with high self-agency, in lower SES groups it may simply result in an acceptance of the negative social identity not the desired behaviour change.

CHAPTER SEVEN:

INTERVIEW RESULTS AND DISCUSSION OF THE 'STRESSED OUT AND ADDICTED SMOKER'

7.1 Introduction

The conceptual maps of participants showed that both addiction and stress emerged spontaneously as key concepts in the images of smokers. This was particularly the case for smokers. A majority (55%) of smokers included addiction in their maps, compared with only fifteen percent of non-smokers. Similarly, stress featured more heavily in the maps of smokers (45%) as opposed to non-smokers (15%). This chapter therefore considers the notion of the 'stressed out addict' in much more detail within the context of the interviews. Addiction and stress are considered together, as they constitute the dominant functional explanations for smoking behaviour, particularly for smokers and were strongly related by participants due to their cyclical nature.

The chapter is structured into two main sections. The first looks at the relatively homogenous conceptualisation of addiction and stress in relation to smoking amongst all participants. The second section looks at how non-smokers/smokers and higher/lower SES participants draw differentially on this conceptualisation and how this might related to some of the material and symbolic contexts which they inhabit. The discussion that follows focuses on the potential consequences for smokers of being labelled 'stressed out and addicted'.

7.2 Results: The conceptualisation of smoking addiction and the stress cycle

7.2.1 The conceptualization of smoking as an addiction

In the interviews, the majority (70%) of participants from all groups spontaneously mentioned the term addiction in relation to smoking. However, although the addiction

discourse was frequently drawn on, it should not be assumed that this necessarily meant that people were taking for granted that smoking is an addiction. Often participants introduced the idea that smoking was an addiction into the discussion as if they were imparting new information to the interviewer in a way they would not, for example, if they were discussing heroin use. In other words, that smoking was an addiction was something that needed to be established. As such, it has the status of a contested 'fact':

'It is an addiction, it definitely is an addiction, no two ways about it'

Participant 21, Smoker, Lower SES, Female, 40-60

A small but significant minority in all groups did challenge whether smoking constituted an addiction at all. This was usually because smoking addiction was seen to contradict another explanation for smoking behaviour, in particular, pleasure:

'I don't see it as an addiction, I think it's something that they enjoy...that's always their [her parents] answer if you ask them to give up, they say it's their one pleasure and we would be taking it away from them'

Participant 25, Non-Smoker, Lower SES, female, 20-40 years old

However, it was more common to see the dominant addiction explanation complementing other explanations for smoking, such as habitual or social smoking and being inter-woven within the same narrative:

'It's like biting your nails, it's a habit, there's not drugs in biting your nails and I think some of smoking is that habit, but I think some of it I think there is actually a chemical addiction to it'

Participant 18, Non-Smoker, Higher SES Male, 40-60 years old

The key motif of smoking was the loss of control on the part of the smoker. The mind-body struggle is played out through the smokers' inability to control their compulsive smoking behaviour:

'It's like it takes over your head completely, there's no other thoughts in the world, nothing else is going on around you, but you just have thoughts of getting that cigarette, and I think that must be an addiction, to get into such a state that you think it is going to be the end of the world if you don't have that cigarette'

Participant 22, Smoker, Lower SES female, 20-40 years old

This loss of control featured in nearly all accounts of smoking addiction. Indeed, it is arguably the marker of smoking addiction for these participants.

All groups also drew heavily on medical and scientific discourse to explain smoking addiction. Most participants were able to identify 'nicotine' as the addictive substance:

'Obviously the nicotine in the smoking is there as a drug, as something that causes excitement and euphoria and that's what nicotine does, the nicotine is there to hook someone on it, if there was no nicotine in cigarettes no-one would smoke them, if it was just like paper on the fire'

Participant 33, Non-Smoker, Lower SES, Male, 20-40 years old

A cyclical withdrawal syndrome was understood to underlie the need for nicotine. Participants identified a range of 'withdrawal symptoms', such as weight gain, mood swings and anxiety, as the result of going without the drug either because of time lapses between cigarettes or during a quit attempt:

'You're getting starved of nicotine basically; your body has come to rely on it. If you have a cigarette, you feel better, you feel relieved when you've had a cigarette'

Participant 7, Smoker, Lower SES, Male, 20-40 years old

There was also consensus that a nicotine addiction was something which might require treatment and intervention. This was either in the form of conventional medicine, such as Nicotine Replacement or alternative methods, such as hypnosis. Participants frequently offered a medical model of treatment for smoking addiction as an uncontrollable illness that requires external help to overcome it:

'You know, if you smoke it is like an addiction, because it is definitely like drug addiction or drink addiction, that's why there are specialised groups to help you give up'

Participant 39, Non-Smoker, Lower SES female, 40-60 years old

In the interviews, the discourse surrounding smoking in relation to other addictions was relatively complex. The underlying concept was a continuum of 'addictions' on which

smoking was then placed. This continuum ranged very widely from behaviours like obsessive exercise and working out, overeating, eating 'forbidden' foods such as sugar, tea, chocolate, caffeine, to other drug substances (considered legal/mild/soft) such as alcohol and cannabis, to 'hard' drug use, such as heroin, cocaine and speed:

'I treat tobacco as a drug. The amount of damage that's done by alcohol, I would think, I don't know, I would think outweighs the damage done by tobacco, which I am fairly confident outweighs the damage done by cannabis or ecstasy or whatever and I imagine that heroin fits in somewhere below alcohol but above tobacco'

Participant 4, Smoker, Higher SES male, 20-40 years old

The placing of smoking on the continuum was relatively fluid, and the same participants would often place smoking at different points depending on the point they were trying to make. If the participant was trying to emphasise the severity of the withdrawal symptoms, for example, they often made comparisons with hard drug use:

'I associate not smoking, giving up smoking as the same as what a heroin addict goes through and people that I have know how used to be heroin addicts have said to me that they have managed to stop heroin but they would never attempt to stop smoking as that would be harder'

Participant 19, Smoker, Lower SES female, 20-40 years old

On the other hand, many participants pointed out that smokers could live relatively normal lives compared with hard drug users and were not in imminent danger in the same sense:

'You have images of dirty needles and cold turkey and being in danger of dying if you don't get whatever you are addicted to, but obviously alcohol and smoking are still addictions but I tend to see them as a sort of lower level of addictions, I don't know why. Well, because there is a need but it's not a desperate need, but it's not for most people too expensive for them to sustain and the side effects of denying yourself alcohol or smoking are probably liveable with but a bit tedious which is why people go back to them more than anything else'

Participant 14, Non-Smoker, Higher SES male, 40-60 years old

Smoking was most often placed in a similar position to alcohol on the continuum. This was because it was perceived to be a legal, social drug with a habitual side:

'When I come home I want to have a glass of wine and if I can't have one, I'm put out and because if someone said to me, if a smoker said to me, well I'll give up cigarettes if you give up alcohol, I don't know whether I would be able to cope with that!'

Participant 15, Non-Smoker, Higher SES, female, 40-60 years old

In summary, most participants identified smoking as an addiction primarily because of the loss of control. Drawing heavily on medical discourse, smoking addiction was conceptualised as a cyclical dependence on the drug nicotine which, if not fulfilled, results in a withdrawal syndrome. Smoking addiction is not understood in isolation, but part of a continuum of drug use.

7.2.2 *The conceptualization of the stress cycle*

Smoking was also strongly linked in participants' minds to the concept of stress. This link between smoking and stress worked on several levels. Firstly, addicted smokers were thought to rely heavily on smoking as a 'crutch'. It is their method of coping with life stressors. As such, they need it to function, thus creating a dependency:

'I've known a couple of people who are dependent on it, psychologically, emotionally, it's a crutch'

Participant 10, Non-Smoker, Lower SES male, 20-40 years old

Participants from all groups also agreed that smoking is experienced as 'calming', 'relaxing' or 'chilling' by smokers. This calming experience is the positive, enjoyable side of stress-relief through smoking:

'It relaxes you, you feel relaxed, I say 'Ahh, I feel better for that'. You don't feel better, you just feel more relaxed. It's a drug, like, it's a drug, you feel more relaxed'

Participant 7, Smoker Lower SES male, 20-40 years old

A final way in which smoking cigarettes is seen to afford stress-relief is through 'time out'. It allows the smoker to escape the specific stressful situation, thus this 31 year old secretary details coping with her demanding boss through smoking:

*'I work with someone who is a right ****hard person at times, not all the time, he can be lovely at times, but sometimes he can lose it and really shout at me and as soon as I walk out of there, before I even lose it or start cursing or run back in there I go straight down and have a fag, sit down there and have one or two fags and then go back and continue as if anything has not happened. Now obviously I'm having to go downstairs to have the cigarette so it could be the break, but obviously I'm thinking that it is the cigarette that's helping me or relaxing me, you think 'ohhh, gimme a fag'*

Participant 23, Smoker, Lower SES female, 20-40 years old

Smoking as a coping mechanism for stress is understood, like addictive smoking, to have a cyclical quality. Many participants pointed out that although smoking could be relaxing, it could also be a source of stress. In particular, the cravings for a cigarette can cause smokers to experience anxiety if they are not able to smoke. As such, the addiction and stress discourses concerning smoking are inter-woven:

'Smokers are not even sure it makes them feel good, because there's this so-called relaxing, more relaxed when you smoke, but they are not sure whether that's true or whether they get uptight for a cigarette, have a cigarette, and therefore feel relaxed because they have participated in something that they wanted to do anyway'

Participant 30, Non-Smoker, Higher SES male, 40-60 years old

In summary, participants identified a stress-cycle connected with smoking. Smokers are understood to use smoking as a form of stress-management, for relaxation and to calm them down. However, this also creates a cyclical dependency. Once smokers depend on smoking as a 'crutch' to cope, they are likely to be anxious when they cannot smoke, and so the stress-cycle is perpetuated.

7.3 Results: Social identity, smoking addiction and stress

7.3.1 Introduction

The above section showed that participants from all groups held a relatively similar understanding of smoking as addiction and stress management. This next section will demonstrate, however, that the different groups in the sample drew on this notion differentially depending on their social identity.

7.3.2 Non-Smokers

The results from the lower and higher SES non-smokers were, in the main, relatively homogenous, so they are initially considered together. Where differences did occur, these are pointed out.

The most striking thing about the addiction discourse of the non-smoking participants is the presence of a continual moral thread concerning addicted smokers. Non-smoking participants claimed that being an 'Addict' often leads to the transgression of moral boundaries. One particularly salient example for them was smoking whilst pregnant or around children due to the compulsivity of the addiction:

'I have seen people who were obviously pregnant smoking, and it's just traumatic really, but that's dependency for you'

Participant 36, Non-Smoker, Lower SES female, 20-40 years old

As the previous chapter on Stigmatisation showed, this particular transgression is the basis for considerable social disapproval; the smoking addict is stigmatised on the basis of their inability to control themselves around 'innocent others'.

Another transgression that some non-smoking participants associated with addictive smoking was the illegal use of contraband cigarettes which associates the smoker with criminality:

'Contraband is another thing, because obviously someone becomes so addicted they are dealing with trying to reduce the cost so they are buying cigarettes that are tax free and you are dealing with a criminal element'

Participant 33, Non-Smoker, Lower SES male, 20-40 years old

On the continuum of drug use, non-smoking participants tended to cluster smoking together with illegal drugs. Some drew on the concept of an 'addictive personality' to explain why smokers would be more likely to engage in other drug taking behaviour:

'They drink, they gamble, they take other sorts of drugs cos it's all part of that trait that they have got, that addictive personality, that addictiveness, which I know could be hereditary as well. It's rare to find an addict of one type or another who doesn't actually also smoke tobacco'

Participant 32, Non-Smoker, Higher SES male 40-60 years old

Again, this association with illegal drug-taking draws the smokers' identity into the realm of the negative addict identity and the associated judgements which accompany it:

'Non-smokers by definition are not going to smoke pot which is the base line of drug taking in their society, that's the boundary of acceptability, so if people are going to take any drugs at all, they'll probably be smoking them or that would be their first port of call'

Participant 9, Non-Smoker, Higher SES female, 20-40 years old

The moral discourse surrounding smoking addiction also identified smokers as 'selfish' for being addicted. Many non-smoking participants conceptualised smoking as a behavioural 'choice'; smokers 'choose' to engage in addictive behaviour. Thus claiming one is 'addicted' does not necessarily, in their eyes, exempt oneself from responsibility:

'I think it is quite selfish also, because everyone know the risks of smoking and as an adult you have obviously gone down that road to take it, same as drug taking, same as if you are an alcoholic'

Participant 39, Non-Smoker, Lower SES female, 40-60 years old

The drawing of these moral boundaries is identity work on the part of non-smokers. By identifying smokers as the 'Other' who break moral norms, they identify themselves as the holders of higher moral standards.

The higher SES non-smoking participants also identified another distinct transgression which tended not to appear in the discourse of the lower SES non-smoking participants. They had a horror of losing control through addiction. Many higher SES participants made positive social comparisons between themselves, non-addicts who are 'in control', and smoking addicts who are 'out of control', as this well-paid young (28) female risk consultant who worked in Central London indicated:

'If you've kind of got a kick out of smoking tobacco or any other drug, then you're just on that continuum of altering your mind state and I just don't want to do that. I sound like such a control freak {laughs} and the other thing I haven't said before is dependency, I don't want any kind of dependency in my life, so I don't want to be dependent on cigarettes to keep me happy. I'm glad it's that way and when I look at my friends who actually say they need a cigarette and they're dependent on them, that's quite horrible'

Participant 9, Non-Smoker, Higher SES, Female, 20-40

Although the stress-relief discourse surrounding smoking was not infused with the same moral censure by non-smoking participants, they nevertheless made use of it for positive social comparisons. Non-smoking participants tended to make internal attributions about smokers concerning stress. It was thought that smokers' internal dispositions, as easily stressed, nervous and anxious, might make them prone to coping through smoking. They tended not to emphasise the role of external or material stressful circumstances, again as Participant 9 shows:

'I do think in my experience smokers tend to be a little bit more erratic kind of people, some of them a bit hyped up. There was a guy, E, at work who was just a complete stress monster and you could almost see him, the way he'd puff at his cigarette, he'd puff faster the more stressed he was'

Participant 9, Non-Smoker, Higher SES female, 20-40 years old

This allowed non-smokers, such as Participant 9, to make positive social comparisons between themselves and smokers on the basis of their greater self-control and ability to cope:

'I actually think that I don't smoke because I don't really feel a need for something like that in my life, whereas I think that other people do actually need something, it's like their stress relief and stuff like that whereas that wouldn't be my sanctuary in any way at all. You know my friend T will sit there with a bottle of vodka and smoke her way through several cigarettes if she's feeling down, but that wouldn't be my way at all'

Participant 9, Non-Smoker, Higher SES female, 20-40 years old

In summary, non-smoking participants added a moral dimension to the image of the 'stressed out, addicted' smoker. Addicted smokers are seen as transgressing numerous social boundaries, particularly for higher SES participants, a loss of control. This

perception provided the basis for many positive social comparisons on the part of non-smoking participants.

7.3.3 *Smokers*

This section examines how the smokers characterised themselves in the light of this moral discourse. The common understandings between higher and lower SES participants are considered first, with differences highlighted subsequently.

Common understandings

One way in which smoking participants tended to minimise any negative comparison with hard drug users was by linking their addiction with other addictions at the 'softer' end of the drug continuum. For example, several smoking participants emphasised their ability to become addicted to other relatively harmless behaviours such as compulsive exercising or working, as Participant 4, a 35 year old male political scientist shows:

'I joined a triathlon club, I mean, talk about addictions, people become just as bloody addicted and just as strange and paranoid and unhealthy in a triathlon club as they do smoking in a pub, I tell you.'

Participant 4, Smoker, Higher SES male 20-40 years old

This may be identity protective in two ways. Firstly, it distances them from the negative spoiled identity of the hard drug addict. Secondly, although they still acknowledge they are the type of people to get addicted, they do so in a way that preserves their self-esteem and presents a more positive social identity, because their 'addiction' is to something perceived as healthy, such as exercise, rather than something unhealthy, such as hard drug use. This was not always the case, however. To emphasise the severity of withdrawal symptoms, smokers often drew comparisons with the withdrawal from hard drugs, as detailed in the first section.

Many smokers, particularly younger ones, also pointed to the socially acceptable use of soft drugs, again minimising the comparisons with hard drug use. For example, this participant blurred the boundaries between labelling people 'smoker' and 'non-smoker' in the context of cannabis smoking to suggest its normality, which may reflect the fact that he himself was a regular cannabis user:

'That's someone having a joint and insisting they are not a smoker, which is ridiculous. I imagine most people have had a joint in their lives and probably have one quite regularly and still see themselves as not being a smoker...where do you draw the line at being a smoker and not being a smoker?'

Participant 11, Smoker Higher SES male, 20-40 years old

A final distancing strategy was to identify 'other' smokers as heavily addicted. Many participants from both lower and higher SES groups acknowledged that smoking is addictive, but drew distinctions between their own, and the addictive smoking of others:

'So there must be a recognition there that I have got a nicotine addiction, but the thing is that I don't smoke 40 a day'

Participant 13, Smoker, Higher SES, Male 40-60

This young (24) male gym receptionist defined addiction as excessive behaviour, and so excluded his own 'social' smoking, including cannabis use, on the weekends with the group of 'lads' with whom he hung out. This definition of smoking as 'pleasure' or 'social' distances the smoker away from a dependent smoker identity:

'My own goes under pleasure. I've never seen myself as addicted to anything. This fella [friend], you've got an addictive personality, he does, he goes from drinking to puffing, and then onto the other stuff, he does it in excess, always does it more than the other person'

Participant 40, Smoker, Lower SES male, 20-40 years old

7.3.4 Lower/Higher SES trends

Although many aspects of the understandings of smoking addiction were similar between lower and higher SES smokers, subtle differences were found. In particular, lower SES smoking participants tended to use more 'drug' language'. 'Drug language'

in this context refers to such terminology as identifying nicotine as a 'drug', smoking as a 'fix', smokers as 'drug addicts' and the symptoms and process of quitting as 'withdrawal' or 'cold turkey'. Lower SES smoking participants seemed happier to characterise smoking as their 'drug habit' in these concrete terms. They also seemed more likely to use terms that have direct parallels with harder drug use, such as 'fix', 'hit', 'injection', 'withdrawals' or 'shakes':

'It's the moment, the moment when you are having your drug injection, I suppose'

Participant 34, Smoker, Lower SES, Male, 40-60

'I get the shakes, I get withdrawals, and it's the same thing with smoke. A bit milder [than heroin] but it's still enough to make you want to go and strangle someone for a cigarette you know'

Participant 7, Smoker, Lower SES, Male 20-40

Lower SES participants also tended to emphasise the loss of control at the heart of their addiction. They spent much time detailing the ways in which this loss of control affects them concretely in their everyday lives within the contexts that they inhabit. For example, this participant was practically house-bound through disability, but nevertheless was prepared to get up in the night and make the trip to the local garage, the nearest source of cigarettes:

'I'm addicted to a cigarette, aren't I? I can't live without a cigarette. If I don't have a cigarette in the house, I'll even go to the garage at three o'clock in the morning and I panic, thinking I've got to have that cigarette. When I get up in the morning, I've got to have that cigarette; I've got to have it!'

Participant 20, Smoker, Lower SES female, 40-60 years old

Many lower SES smokers also detailed how smoking is embedded in their everyday lives as a coping mechanism. This was particularly the case for a sub-group of lower SES single mothers who smoked (lower SES men tended not to link their smoking with emotional stress). They linked their smoking directly to the stress of their life-circumstances, such as caring for children, finding money for the family and coping

with periods of ill-health. This participant indicates her lack of coping resources, such as family around her, which she thinks is linked to the context of isolation of living away from her relatives in London:

'I'm not saying the whole of the world, but a lot of single mums, in fact all the single mums I've ever known have smoked. I think that with being a single mum, especially in London, there is less and less extended family, so you know, you can be a single mum and then not necessarily got your immediate family, mums, dads, aunties in the area where you live, so you tend to have a cigarette. It's your comfort'

Participant 19, Smoker, Lower SES female, 20-40 years old

These lower SES mothers had all tried to quit smoking. However, despite these numerous, sometimes successful quit attempts, cigarettes have for these women become entrenched as their normal way of coping:

'It's like you know you've always made good decisions when you have been smoking, it can be quite scary when you are not smoking and you do come up against all these grievances, it's like will I make the best decision now? It's kind of freaky'

Participant 22, Smoker, Lower SES female, 20-40 years old

As such, they made self-identifications as 'stressed-out' smokers who find it difficult to cope. Negative social comparisons between themselves and non-smokers are made on this basis. This participant in particular had had to cope with many life-crises in terms of ill-health and the abuse of her children which had challenged her feelings that she could cope without cigarettes:

'Non-smokers do tend, I feel, to cope better, they're not constantly stressing for a cigarette when a crisis happens, where smokers, including myself, when a crisis happens straight away it's one cigarette after another so you're concentrating on the nicotine and not necessarily concentrating on what's happening in the crisis'

Participant 19, Smoker, Lower SES female, 20-40 years old

The notion of the 'stressed out, addicted' smoker differed amongst higher SES smokers in several ways. Firstly in terms of addiction 'drug language', this was far less prevalent amongst higher SES smokers. They did not tend to describe a cigarette as a 'fix' or a

'hit' or withdrawal as 'going cold turkey'. Two higher SES smokers did use the term 'addict' to describe themselves, however it had more of a resonance of an Alcoholics Anonymous confessional than using concrete drug terms:

'I know people who are social smokers and people who are like myself, who are definitely addicts'

Participant 18, Smoker, Higher SES, Male, 40-60

Secondly, given the distinctive horror of the loss of control smoking addiction represents for higher SES non-smokers, it is perhaps not surprising that higher SES smokers also were keen to distance themselves from this unpalatable side of the addictive identity. Overall, higher SES smokers did not tend to detail a loss of control of smoking in their everyday lives. Several participants emphasised that their smoking represented a life choice:

'I've made choices about which particular drugs I take, and they are alcohol and cigarettes, cigarettes decreasingly'

Participant, 4, Smoker, Higher SES, Male 20-40

Other higher SES smokers distanced themselves from the identity of the compulsive addict by explaining the functionality of their drug of choice, often in a creative context. Thus this black female artist aged 39 described her use of smoking as a creative tool:

'Basically I find that it gives you a mental buzz and the music flows a bit better, I feel. You do treat it as a drug then...'

Participant 6, Smoker, Higher SES Female, 20-40

Finally, several of the higher SES smokers offered chemical/genetic level explanations of addiction that did not tend to appear amongst the understanding of the lower SES smokers:

'If I had to classify myself, I would put myself in the genetic addiction camp'

Participant 11, Smoker, Higher SES, Male, 40-60

Higher SES smoking participants also tended not to portray themselves as a 'stressed out' smoker for whom smoking is embedded as a way of coping, for example, not using the term 'emotional crutch', either about themselves or others. They also placed less emphasis on smoking as a consequence of a nervous/stressed personality and very few, if any, identified their own personality as anxious or nervous. Rather higher SES smokers drew boundaries between their own smoking and that of 'other smokers' who are the ones who are stressed out:

'The other image I have is of someone who is quite a heavy chain-smoker, maybe more of a stressed type of personality, it's more stress and nervous. I'm more of a social smoker'

Participant 2, Smoker, Higher SES female, 20-40 years old

In contrast to the lower SES smokers, no higher SES smoker admitted to thinking about cigarettes during the interviews. Rather smoking in response to stress is played out primarily as a response to the context of work-place pressure. Smoking is perceived as a way of 'handling' a high pressure work situation in which achievement is valued, albeit one which is deemed 'unhealthy':

'It is partly why I smoke, the pressures of work and I associate it with people in offices, you see people outside buildings smartly dressed really desperately smoking because they can't obviously smoke in their office environment and they need some sort of buzz because they are under pressure'

Participant 13, Smoker, Higher SES male, 40-60 years old

Thus the emphasis is on smoking as taking beneficial-time out in a 'work hard, play hard' job environment rather than an inability to cope with daily life or as a reaction to emotional stress, as this IT consultant in his mid-thirties explained:

'My smoking time is my thinking time, so quite often I don't know I you know I work in IT, so we have problems, be it a coding problem, be it any kind of problem, and I do find, whether it is just the result of just being able to spend some time by myself, or whether it is the smoking itself, I don't know, but I do find that I can have a flash of inspiration whilst I am outside smoking'

Participant 18, Smoker, Higher SES male, 20-40 years old

Several higher SES smoking participants also found ways to make favourable comparisons with non-smokers on the issue of stress-relief. This higher SES smoker, for example, identified non-smokers as calmer (a negative social comparison), but also pointed out that they may avoid the context of being under pressure, thus introducing another dimension on which he, as a smoker, might positively compare:

'People who don't smoke are of a different metabolism, like M (my wife) who doesn't feel at all the urge to smoke despite having all the normal work pressures of going to work and so on, so they are either basically calmer in their whole approach to life, or they have managed to avoid situations which can either intensify pressures on you'

Participant 13, Smoker Higher SES male, 40-60 years old

Others directly challenged the non-smokers' claim to be superior due to better stress management:

'Stress reactions are still an issue, it's just those people chose different means to deal with, different means of satisfying those same triggers, right? I don't think it's a correct idea that a non-smoker is thereby a healthy person because they might choose all sorts of unhealthy ways of meeting the same cravings'

Participant 4, Smoker, Higher SES male, 20-40 years old

In summary, smoking participants tended to draw on the conceptualisation of the 'stressed out, addicted' smoker in way which were identity protective. They tended to link smoking with less harmful addictions, highlighted the socially acceptable nature of soft drug use and identified 'others' as the addicted smoker. The exception to this was to draw comparisons between withdrawal from nicotine and hard drugs to emphasise the difficulty of quitting.

There were subtle differences between lower and higher SES groups. Lower SES smoking participants used 'drug language' extensively and detailed a loss of control in respect to smoking. A sub-group of single mothers in particular identified themselves as the 'stressed out' smoker, for whom smoking is their primary coping mechanism or 'emotional crutch' in the context of high life stress and few coping resources. In

contrast, the higher SES smokers tended to distance themselves from the identity of the 'stressed out addicted' smoker, using less 'drug language'. They also emphasised the control they had over their drug use, smoking or otherwise. Higher SES smoking participants also tended not to identify themselves as stressed out, neurotic or having an inability to cope. They emphasised their stress-related smoking 'made sense' in the context of a high-achieving workplace, which places an emphasis on 'getting the job done' whatever it takes.

7.4 Discussion

To summarise, the addiction and stress discourses were considered together in this chapter as they constitute the dominant functional explanations of smoking. The discourses are also entwined, as smoking as a coping mechanism is perceived to have a dependent, cyclical quality: the 'stressed out' smoker is also likely to be the 'addicted' smoker. The results show that at the heart of the lay conceptualisation of smoking addiction is a loss of control, as the bodily needs for the drug 'nicotine' leads to a battle with the mind or 'will' of the smoker. Group trends could also be observed. Non-smokers from both SES groups tended to emphasise the link with harder drugs, and added a moral discourse, providing the basis for positive social comparisons. Smoking participants as a whole tended to distance themselves from this 'addict' image by linking smoking with less harmful addictions and identifying 'others' as addicted. Lower SES smoking participants, however, were happier to make salient the loss of control they experience in daily life through addictive smoking and the psycho-social stress which perpetuates it. Higher SES smokers, on the other hand, often emphasised the control they had over their drug of 'choice', as well as its role as a coping mechanism in the context of a high-pressure, achievement oriented work-place and the demands of being 'professional'.

Research has suggested that smokers perceive smoking to have multiple functions (Laurier et al, 1999; McKie et al, 2002). This is very much in evidence here. Participants, both smokers and non-smokers, identified addiction as one amongst a range of explanations for smoking, alongside habit, boredom, time out, stress-management and coping and pleasure. Sometimes these explanations were seen as mutually exclusive. For example, Participant 40, a young male smoker who tended to smoke (often cannabis) whilst 'partying' and 'giving it large' on weekends, distanced himself completely from the notion of addiction, classifying his smoking as 'pleasure'. Amos et al., (2006) have identified this 'social' conceptualisation of smoking as at the extreme of a continuum of dependent smoking for adolescents with 'real' or 'full-fledged' smoking at the other end (also see Johnson et al., 2003). The presence of this understanding amongst some of the younger age group in the sample (which ranged from 20-60) suggests a continuity of the 'social', non-dependent, identity for many smokers into their twenties. However, it was more common for participants of all SES to see addiction entwined with other explanations of smoking, such as habit, corroborating the findings of Laurier et al., (1999) and McKie et al (2002).

Gillies and Willig (1997) have argued that addiction now represents a dominant construction of smoking (also see Louka et al., 2006). The results here lend support to this proposition. Firstly, the majority of participants spontaneously mentioned 'addiction' to the interviewer themselves rather than the other way around. Secondly, participants drew extensively on a bio-medical and scientific discourse to explain the smoking-addiction link. They identified the drug as 'nicotine', explained the process of dependence using physiological and psychological terms, and outlined the medical symptoms of a 'withdrawal syndrome' and potential treatments. Thirdly, participants understood smoking as part of a continuum of addictive substances and behaviours,

which ranged from less harmful addictions to sugar, caffeine or exercise, through to hard drug use.

It is interesting to note, however, that participants in these interviews did not take for granted that smoking was addictive. It had the status of a contested fact, evidenced by the way many participants introduced the concept of 'addiction' into the interview as if they were imparting novel or controversial information; 'it is an addiction, you know'. This suggests that the medicalization of smoking (e.g. Penn, 1998; Gillies & Willig, 1997) is not homogenous or complete; addiction, although dominant, is only one of a number of discourses on which people draw to understand their own and other's smoking.

It is relatively pervasive, however. For example, this analysis shows that participants frequently use 'drug language' to talk about smoking. 'Drug language' is the use of terminology originally concerning other drugs, now applied to smokers and smoking, such as 'drugs' 'users' 'drug addicts' 'going cold turkey' 'hit' or 'fix'. The use of generic drug language in relation to smoking has undoubtedly has been pioneered by health professionals, motivated by their desire to have smoking nicotine accepted as equivalent to hard drug use (see Chapter Two on the RCP's report, 2000). For example, a certain type of US nicotine was named 'free-base nicotine' by researchers studying it as it vaporizes easily and produces a 'kick' effect. Clearly the intention through this labelling is to link nicotine with other substances such as crack. Another example is the term 'chipper', originally a slang/street term for non-dependent occasional heroin users, now appropriated by the smoking research community to describe non-dependent smokers (e.g. Sayette, Martin and Wertz, 2001). This 'drug language' is routinely incorporated into smoking research which is then widely reported in the mass media. The analysis here suggests that 'drug language' may be is a common feature of smoking

discourses amongst smokers, which may reflect the prevalent cultural narrative in the UK of smoking as a problematic addiction (Louka et al., 2006)

'This raises the question of the consequences, in terms of social identity, for identifying the smoker as such. One consequence is that it draws the smoker at into the conceptual sphere of addictive drug use. Hammersley and Reid (2002) have argued that the 'addiction' myth is a socially and culturally (dis-)functional set of beliefs concerning substance use. It is an illustration of how not to behave. Being an 'addict' or 'addicted' transgresses boundaries of health, personal responsibility and self-control. 'Good' individuals can show their mastery of these values by not being an addict. 'Addicts', on the other hand, have a morally unacceptable identity, although as part of the 'myth' is that substance use is uncontrollable, they have legitimate claims for 'treatment'.

Although Hammersley and Reid (2002) argue that this addiction 'myth' has tended to exclude legal drugs such as tobacco, the findings here contradict this. Non-smoking participants here associated smoking with other drug use, particularly at the harder end of the continuum, such as alcohol and illegal drug use, rather than with softer or more harmless addictions such as to chocolate or exercise. This implicitly links smokers with the 'spoiled' identity of harder drug users (Waldorf and Biernacki, 1981) rather than the 'fun-loving' identity of a pleasure-seeker. Secondly, non-smoking participants add a pervasive moral seam to their judgements of the addicted smoker. Rozin (1999) has argued that in the U.S. smoking constitutes a textbook case of moralisation in which something which was considered a personal preference is now characterised as a moral violation. Louka et al., (2006) suggest that this is also very much the case in the UK, where the smoker is the subject of moral judgements, particularly over their inability to control their addiction. The non-smokers in this sample pointed, for example, to the pollution of 'innocent others' through smoking whilst pregnant or around children.

Smokers were labelled 'selfish', lacking future forethought and evading personal responsibilities. The introduction of this moral discourse is identity work on their part. Given that responsibility, control and self-discipline are key Western values (Crawford, 1994; Joffe & Staerkle, in press) the identification by non-smokers of the smoker as the 'out-of-control Other' has the effect of enhancing, and perhaps justifying, their own higher social status at an ideological level.

Non-smokers in this sample were also keen to identify themselves as good at coping with stress. Smoking as a means of coping with stress has been identified as a strong discourse amongst disadvantaged smokers, particularly women (e.g. Bancroft et al., 2003; Graham, 1993 a and b). For non-smokers, therefore, the identification of the smoker as 'stressed out' represents the opportunity to identify themselves as the type of person who copes well in the context of a Western industrialised society, where working hours are long, and where at a symbolic level, to be 'professional' is to embody the values of achievement, self-control and self-discipline (Crawford, 1994; Joffe & Staerkle, in press). It is also interesting that the non-smokers here made predominantly internal attributions for this difficulty with coping with stress. In other words, they tended to perceive smokers as psychologically disadvantaged in some sense, such as easily stressed, nervous, anxious-type people, rather than explaining their smoking in terms of external or material contexts. There were some exceptions to this, for example, if the smoker had undergone stressful life events, such as the death of a relative. Nevertheless, the emphasis was on the faulty internal disposition of the smoker; the responsibility (and blame) therefore rested with them.

In the face of the potential association with a socially devalued identity, the smoking participants in the sample also engage in much identity work. Research with young smokers has shown that many draw boundaries between themselves and 'other' smokers

on the basis of dependence (e.g. Amos et al., 2006; Moffat & Johnson, 2001). Amongst young people, this boundary-drawing tends to be between 'social' or 'ambivalent' who are in control, and the 'real' addicted smoker (Amos et al., 2006). Here, in this adult sample, boundaries were also drawn on the basis of addiction. However, the 'other' smoker was always the one who smoked a greater quantity of cigarettes than the speaker. Thus a twenty a day smoker might class a forty a day smoker as heavily addicted, whereas someone who classified themselves as a 'social' smoker who smoked mainly on weekends might identify someone who smoked regularly every day throughout the week as heavily addicted. In nearly all cases, the smokers who drew these distinctions would, by research classification, be designated as 'addicted' (RCP, 2000). This suggests that this identification of the 'other' smoker as the addicted one is identity work, motivated by the negative associations of 'being an addict', rather than any attempt to objectively assess their dependence on nicotine.

Research has suggested that smokers draw on the term 'addiction' alongside terms such as 'habit' for rhetorical purposes depending on the point which they wish to make (Bancroft et al., 2003; Laurier et al., 1999; McKie et al., 2002). Furthermore, these accounts of addiction are not always consistent (Laurier et al., 1999). Laurier et al. (1999) argue this is because people don't have a fully-formed, internally consistent health belief model which they map onto practices (also see Billig, 1987). There is certainly evidence of this rhetorical, and seemingly inconsistent, discourse concerning addiction from the smoking participants in this sample. At some time points, smokers distanced themselves from the 'hard' end of drug use by asserting that their own addiction was at the 'softer' or 'less harmful' end of the addiction continuum, for example, they draw parallels with excessive exercise or indulging in chocolate. This re-creates the addictive identity in a positive social way, as something healthy or indulgent,

carrying connotations of living life to the full and pleasure rather than harmfulness. On the other hand, sometimes smokers drew parallels with harder drug use, particularly to emphasise the difficulty of quitting and the severity of withdrawal symptoms, in line with the findings of McKie et al., (2002). This may function to mitigate smokers from blame if they find quitting difficult. It also offers a 'medical' explanation for their behaviour rather than one which is based on a failure of will or moral reprehensibility.

This illustrates perhaps a paradox for smokers in drawing on addiction discourse. On the one hand, the addiction discourse appears to offer mitigation against blame and responsibility. Someone who is addicted is, by definition, 'out of control' and therefore not responsible for their actions. Furthermore, the classification of smoking addiction as a medical disease implies that, like all diseases, it is worthy of treatment. On the other hand, letting oneself become 'out of control' is seen as morally irresponsible as well as a sign of personal weakness, particularly by the middle-class (Hammersley & Reid, 2002). Thus smokers do not always position themselves consistently in respect of this addict identity but rather draw on it differentially, and sometimes inconsistently, to maintain their social self-esteem.

There were also different nuances in the addiction/stress discourse used by smoking participants from lower and higher SES groups. Looking first at the higher SES smokers, several distinctions are apparent. They tended not to use 'drug language' so extensively. This might be understood in two ways; firstly, at an identity-protective mechanism, it distances the middle-class smoker from the negative associations with hard drug use. Secondly, few of the middle-class smokers in this sample talked about encountering significant hard drug use in their life-contexts although many mentioned cannabis use by themselves or others. The lack of 'hard drug' talk may therefore reflect their socio-cultural and material advantage to some extent. Rather, they tended to

emphasis their smoking as 'under control' and as a 'rational choice', particularly in their social and work contexts of being a 'work hard, play hard' type of professional. Smoking is perceived to be a valid, if unhealthy, response to stress in a high pressure work environment in which achievement is valued. Thus their identity as 'in control' smokers 'makes sense' (Radley, 1999) in the context of the need to be a 'professional' according to the Western industrial work-ethic.

It might be thought that this ability to achieve identity cohesion by integrating smoking identities with other important social identities, such as being 'professional', might deter quit attempts amongst higher SES smokers. However, higher SES groups have the highest quit rates, despite working in (perceived) high-pressure contexts (Lader & Meltzer, 2004). In fact, the pervasive identity work surrounding being a middle-class smoker hints at the dissonance of values underlying it. Ultimately, stopping smoking offer the opportunity for middle-class smokers to come into line with their own internalised (and socially acceptable) values in their social and work contexts in which non-smoking is largely normative.

There were many similarities between the understandings of stress and addiction amongst the lower SES smokers in this sample and previous research with disadvantaged groups (e.g. Bancroft et al., 2003; Graham, 1993 a and b). Many lower SES smokers (although not all) emphasised that their smoking was of a highly dependent nature. For example, several reported that sitting in the interview without a cigarette for an hour or more quite uncomfortable. This may be because, in comparison with the higher SES smokers, they were more dependent, for example 47% of manual workers are heavily dependent (HEA, 1998). However, 39% of professionals are also classified as highly dependent (HEA, 1998), yet as a social group, they are very reluctant to conceptualise themselves as 'out of control' in relation to smoking. This

suggests that the portrayal of lower SES participants of themselves as addicted is partly one of perception as much as physiology and may reflect an internalisation of this negative social identity.

Secondly, there was a sub-group of single mothers in this sample whose accounts of coping through smoking resonated considerably with those already identified by Graham (1993a) who argued that lone mothers perceive smoking as a coping mechanism in the face of caring responsibilities and few material resources. There was a slight difference in emphasis due to the sample here, however. None of these women had small dependent children, rather they had teenage or older children, so their emphasis was on their stressful life history, such as being left, coping with abuse, having significant ill-health or being disabled and the lack of social support in their surrounding area. Their account was one of emotional vulnerability brought on through the context of social disadvantage and extreme life-stress. It is interesting to note that none of the lower SES men described themselves as coping emotionally through smoking. They were more likely to describe their coping through smoking as taking 'time out'. This suggests that understandings of smoking amongst lower SES groups are consonant with existing gender identities in which women are characterised as 'emotional' (Gillies & Willig, 1987).

It is also interesting to note that few of the female higher SES smokers tended to characterise their smoking in terms of being the 'vulnerable female', preferring to emphasise its role as a tool in a 'work hard, play hard' workplace context with masculine values. What this suggests is that middle-class female smokers actively position themselves away from a disempowered 'emotionally dependent' female identity. This represents an extension into adulthood of the 'girl power' notion of smoking as a life choice made by teenage girls (Denscombe, 2001). On the other hand,

the self-identification of the female lower SES smoker as 'powerless' as evidenced by their smoking may perpetuate their devalued social position.

A final difference in nuance between the addiction/stress discourses of smokers is the more prevalent use of 'drug language' by the lower SES smokers, speaking of their 'fix' or 'withdrawals'. Although quite a subtle difference, this suggests an acceptance of the harder edge of smoking addiction. This may reflect their socio-economic contexts, as a few (but by no means all) lower SES participants reported having known friends/acquaintances, or simply 'people in the building' who used hard drugs. It may also reflect a symbolic internalisation of the addiction discourse.

Some commentators (e.g. Gillies & Willig, 1997) have suggested that the addiction discourse is generally disempowering as it encourages smokers to think of themselves as 'out of control'. It could be particularly problematic for disadvantaged smokers, who already have lower perceptions of self-efficacy (Chamberlain & O'Neill, 1998) and reinforce the idea that it is impossible to quit. This is not to say that an approach based on an addiction model of smoking is of no help to health professionals concerned to promote quitting amongst lower SES groups. Not least, it locates health promotion where the audience is thinking (Joffe, 1996). However, if an addiction model is used, it should emphasise its treatable nature, not its uncontrollability.

It is also worth noting that the dominance of the addiction discourse found in the interviews of these participants may reflect certain characteristics of the participants. For example, several of the lower SES participants were sourced from the Camden and Islington Smokers' Clinic lists of those who had registered interest but never attended. However, although they had not participated in any of the programmes, these individuals may be more likely to be oriented around quitting and subscribe to a treatment model of addictive smoking than is prevalent amongst other smokers. In terms

of age and gender, which as this discussion has shown are also connected with distinct addiction discourses, equal numbers of men and women were sampled and their age noted in the tables in the Methodology chapter. This is not an attempt to 'control' these factors, although they are not the primary focus of study in this analysis, but rather to ensure that different perspectives were reflected in the results.

7.5 Conclusion

This chapter has examined the primary functional explanations of smoking that appeared in the interviews, namely addiction and stress. There is no doubt that the salience of these understandings reflects the socio-cultural and ideological dominance of the bio-medical addiction model currently in the UK. The notion that smoking is addictive was not uncritically accepted by participants, reflecting perhaps, its relatively recent, and controversial, status as a 'medical addiction' similar to hard drug use (RCP, 2000).

This re-classification of smoking as an 'addiction' has considerable consequences for the identity of the smoker. It draws them into the conceptual fold of hard drug use, with its moral discourse and 'spoiled' identity, although it also provides a rationale for medical treatment (Waldorf and Biernacki, 1981; Hammersley and Reid, 2002). Ultimately, the identity of the 'stressed out, addicted' smoker is socially undesirable as it represents 'loss of control', in line with the socio-cultural valuation of control (Joffe & Staerkle, in press). Non-smokers and higher SES smokers tend to draw on this conceptualisation in ways which are, in the main, identity enhancing or at least protective. The exception to this is the understanding of the lower SES smokers, who show evidence of internalising this negative social identity. Smoking cessation approaches need to be aware of the need to challenge the powerlessness of the smoking discourse amongst lower SES groups, not compound it.

CHAPTER EIGHT: INTERVIEW RESULTS AND DISCUSSION OF 'THE UNHEALTHY SMOKER'

8.1 Introduction to chapter

As Chapter 5 showed, poor health was a core part of the images of smokers in the conceptual map and, correspondingly, good health part of that of the images of non-smokers. This central aspect of smoking identities is examined in this chapter using the interview material. The results section is divided into three parts. The first considers the definitions of general health given by participants, paying particular attention to potentially important SES differences. The second considers the understandings of smoking related ill-health and death as part of smoking identities, focusing on the notion of invulnerability to risk. The third section considers the understanding of health consciousness and lifestyle choices by the participants, concentrating particularly on the way in which the different SES and smoking status groups utilised the concept of being 'healthy' in relation to smoking to draw social boundaries. The discussion section that follows considers the implications of this identity work in the current socio-cultural context of 'healthism' (Crawford, 1994) and the need to be 'in control' of ones' health (Joffe & Staerkle, in press). It considers how smoking identities created in this symbolic context might contribute to the differential social status, and health, of SES groups.

8.2 Results: Definitions of generic health

To tap generic definitions of health, participants were asked how they would describe health in general and how they felt when they were healthy. Three major definitions of health emerged in the interviews; health as not-ill (a state of absence of disease), health as well-being (a state of enhancement) and health as behaviour (an action-based state).

Participants from all four groups (higher and lower SES smokers and non-smokers) utilised these three definitions. Nevertheless, group differences in emphasis did emerge.

The first of these definitions of health is 'health as not-ill', the absence of disease. This includes a functional aspect, so that people who are 'healthy' by this definition are able to undertake everyday tasks, such as walking, doing their job and socialising, as this male aged 54 who had worked as a welder all his life explained:

'General health is somebody who wants to do whatever they want to do and they feel quite comfortable about doing it. Now that sounds very vague, but take my brother in law, he has never been a sporty person, but as he gets older, he likes to play golf and I play with him, so it's the extending of your life through health, I think'

Participant 34, Smoker, Lower SES male, 40-60 years old

This was the definition of health that is dominant amongst lower SES participants, particularly smokers, with the vast majority mentioning it. It appeared less prevalent amongst the higher SES participants.

Consequently, many lower SES smokers described themselves as 'healthy' according to this definition of health as the absence of disease. Thus this female smoker in her early thirties (31) who worked as a secretary said of herself:

'I am pretty healthy, touch wood. I've never been, thank god, ill, so how that is I don't know, I smoke, I don't eat vegetables, but...no, I'm pretty happy with my health, to be honest with you.'

Participant 23, Smoker, Lower SES female, 20-40 years old

In contrast, the majority of higher SES participants showed a preference for another definition of health and healthiness, centred on activity and behaviour. Here, 'health' is defined according to the performance of a triad of 'healthy' behaviours, specifically exercising, eating well and not smoking:

'I suppose it's a bit of a corny image, but something like Centre Parcs, with people, families going out together and walking or cycling and swimming, being

outside, maybe in the country, preferably nice weather. I also think what people eat, some food seems really healthy and to promote health, like salads and fruit'
Participant 15, Non-Smoker Higher SES female, 40-60 years old

It is interesting to note that the lower SES smokers quoted above who considered themselves 'healthy' on their own definition of 'health as not-ill' would not qualify as 'healthy' according to the behavioural criterion preferred by the higher SES participants.

The third major definition of health that emerged in the interviews, more or less equally across all groups, was that of 'health as well-being'. According to this definition, 'health' is a positive state of being, not merely the negative absence of disease. It incorporates ideas about the enhancement of life through health, such as happiness, well-being and enjoyment:

'Walking down the road, smiling, a spring in my step, that's healthy. It's like enjoying life'

Participant 31, Smoker, Lower SES male, 40-60 years old

Additionally, a few smokers also defined health as 'normal' or a state of 'normality', in contrast to non-smokers who do not mention this at all:

'Clean-living, fitness. A normal person all round basically. Smoking- it's not normal, is it?'

Participant 7, Smoker, Lower SES male, 20-40 years old

In summary, three major definitions of health emerge in the interviews; 'health as not-ill', 'health as well-being' and 'health as behaviour'. Lower SES participants tended to refer to health more frequently as the absence of disease, whereas higher SES participants considered the behavioural criterion of health as the most important. Both drew equally on the concept of 'well-being' as an essential part of health.

8.3 Results: Ill-health, death, risk and invulnerability

Moving beyond generic definitions of health, this section looks specifically at the link between smoking and ill-health, disease and death as understood by the participants from the different SES and smoking groups. Particular attention is paid to the way in which smokers and non-smokers drew on the concepts of risk and invulnerability.

Non-smokers from both higher and lower SES groups presented a relatively homogenous and coherent picture of the health effects of smoking, so they are presented together below. The key point of their accounts is that smoking often leads to death. It is frequently referred to as 'killing yourself':

'I have a problem reconciling in my head how anybody intelligent can do something which is clearly killing you. I just don't understand it, you wouldn't drive at a brick wall repeatedly to see if it actually killed you, but it's the equivalent of what they're doing.'

Participant 9, Non-Smoker, Higher SES female, 20-40 years old

Smoking was also seen in terms of 'risk'. Smokers are 'at risk' of 'ill-health' or 'sickness' or 'harm'. This is primarily a long-term 'risk' in which the results of one's smoking might not become apparent until twenty or thirty years later, although there may be minor symptoms in the short-term. Thus smokers are seen as being 'caught up with' at a later date:

'The more you smoke, the less healthy you are or can be. Obviously someone might be smoking a lot today and feel fine, but I personally feel that it will catch up with you sooner or later. There is a price to be paid'

Participant 12, Smoker, Lower SES male, 20-40 years old

Smoking was also associated with specific diseases. These included all types of respiratory problems including lung cancer, emphysema, bronchitis, breathlessness, chesty coughs; heart problems, disease, bypass or surgery; cancer generically; and poor circulation including amputation:

'You'll get emphysema or your heart will pack up or you might end up having your legs cut off because your circulation or arteries are all tarred up. So it's not just cancer, there are lots of other related things'

Participant 9, Non-Smoker, Higher SES female, 20-40 years old

Although participants found it generally quite easy to identify the diseases they associate with smoking, they found accounting for the mechanism behind it more problematic. The most common metaphor used to explain exactly how smoking causes these diseases was one of pollution. The smoke (and to a lesser extent the tar) was described as an unnatural pollutant which creates toxic effects:

'I just say it is that you are taking something into your body that is not natural and that you don't need. If your body doesn't need it, it's like a toxin going in, your body can't cope and then it starts shutting down or whatever'

Participant 24, Non-Smokers, Lower SES female, 20-40 years old

Non-smokers focused extensively on the health effects of smoking. For them, the smokers they knew who had become ill through smoking had high saliency. There tended to be a socio-economic difference; lower SES non-smokers were more likely to mention having experienced smoking-related death and illness in the immediate family or contemporary younger members (such as uncles and friends) as well as grandparents whereas the higher SES non-smokers tended to identify illness only in the older generation:

'Someone I knew of literally lost their one leg through gangrene due to smoking and they carried on until it killed them. Once their leg had gone the doctor said, 'well if you give up now you should be OK, you've lost that, but if you carry on...' They carried on and bloody well killed themselves. If that's not the thing, then I don't know what is!'

Participant 8, Non-Smoker, Lower SES male, 20-40 years old

Whatever their personal experience, the non-smoking participants all agreed on one thing: that the majority of smokers are in denial about the health risks and consequences of smoking. The identification of an 'it won't happen to me' syndrome was a prominent part of their accounts:

'If you talk to any smoker, they will say that it is not statistically proven and it is more dangerous to cross the road and you could get hit by a bus or an aeroplane might fall on you and they will give you all of these statistics, all of these reasons why they should still be allowed to smoke, which is still a form of denial'

Participant 33, Non-Smoker, Lower SES male, 20-40 years old

The accounts of the non-smoking participants were relatively homogenous. Amongst the smoking participants, SES trends did emerge. Their accounts are therefore considered separately and contrasted where appropriate.

Looking firstly at the lower SES smoking participants, there was little sense of a challenge to the main concept presented by non-smokers, that smoking is intrinsically linked to ill-health and death. Indeed, the use of death as a metaphor appeared to be as or more frequent than with non-smokers. For example, one ill colleague of a lower SES smoker was described as a 'walking skeleton'. Several lower SES smokers reported that their families or friends tried to scare them by pointing out 'smoking will kill you':

'I was up at my cousins and he said to me 'why do you smoke' and I said 'it's a good question, I wish I knew the answer' and he turned round to me and said 'I don't want you to die'. That hits home, that really does hit home'

Participant 31, Smoker, Lower SES male, 40-60 years old

Indeed this male smoker (aged 39) who smoked about 40 a day recounted a story of seeing a dead body in a graveyard when he was a teenager and being told this is the 'body of a smoker', although he revealed that this didn't stop him becoming a heavy smoker in later life:

'A guy I used to know, each to their own personally, but he used to grave-dig in his spare time, but me and my friend, we used to scare the living daylight out of each other, we went onto this grave, it was an open grave you know, waiting for someone to be put into it. He opened it up, the body wasn't covered up properly, it was all moved, there was a smoker that was in there supposedly...put me off smoking for the day, summer of '79'

Participant 7, Smoker, Lower SES male, 20-40 years old

A few higher SES smokers did also mention 'death' in relation to smoking. However, the tone of their discourse was more neutral and less emotional than that of the lower SES smokers. However, they tended not to report so many family members or friends nagging them about 'killing themselves'. For some higher SES smoking participants, moreover, the death discourse brought out their defiant side, such as for this male political scientist in his thirties:

'You know the Death brand cigarette. Ah god, that's just hilarious. That's just proving my point about this, the more you tell me it's bad for me, the more I'm going to do stuff that's really insane, like smoking cigarettes that say 'Death' on them, or calling them coffin-nails, all this kind of thing, gallows humour'

Participant 4, Smoker, Higher SES male, 20-40 years old

Another young female post-graduate student (higher SES) aged 23 re-characterised this association with death in a positive manner, invoking connotations of control over her own fate:

'I know it's really bad for me, I know it may possibly almost definitely kill me, but I like the fact that you're taking your fate into your own hands and that it forces you to say 'do this and it may really harm you', but I think it's probably the control that it gives you, that you can say that yourself, but yet still do it.'

Participant 1, Smoker, Higher SES female, 20-40 years old

Turning now to the consideration of smoking-related disease, both lower and higher smokers identified, as did the non-smokers, a range of illnesses which smokers are 'at risk' of suffering from lung problems, heart problems and circulation. Lungs in particular were a source of concern for smokers, with many worried about the effects of smoking on their own lungs, either because of their own breathlessness, the 'cough' of the older smoker or the spectre of lung cancer, as this 40 a day smoker indicates:

'Oh, smoking doesn't do you any favours. It attacks the lungs you know. I think it makes your lungs heavy with all that tar in there'

Participant 7, Smoker, Lower SES male, 20-40 years old

In comparison with non-smoking participants, both lower and higher SES smoking participants tended not to focus so much on the smoking ill-health of others in their social circle. Lower SES smokers tended to highlight a greater number of experiences of smoking-related ill-health in their immediate social environment than the higher SES smokers. These were often diseases of a serious nature, such as lung cancer, heart disease or even amputation:

'My dad has got hardening of the arteries and their [the children's] dad is a very heavy smoker, more heavy than me, heavy smoker, and his dad died at a young age, so they are very worried about the effects'

Participant 19, Smoker, Lower SES female, 20-40 years old

In contrast, very few of the higher SES smokers tended to mention such severe illnesses, although they did show concern over the breathing problems associated with smoking:

'My dad used to smoke, and he definitely has problems now. I'm not sure exactly what it is, but he definitely has breathing difficulties and has been put on medication recently in the last couple of years. I've never known anyone who's died of lung cancer or anything like that'

Participant 3, Smoker, Higher SES female, 20-40 years old

Similarly, when talking about their own health in relation to smoking, lower SES participants highlighted often quite serious health difficulties such as bronchitis and pneumonia, as Participant 7, a heavy 40 a day smoker shows:

'My voice was just quivering with the pain and everything, so I was admitted to the Jupiter ward for a week. There was about three or four people there with all the same thing, you know. All smokers and they all had pneumonia.'

Participant 7, Smoker, Lower SES male, 20-40 years old

They also often mentioned their experience of smoking ill-health alongside other concurrent chronic conditions. Several of the lower SES smokers also had chronic pain, asthma or diabetes:

'Well, I've got very bad health, H, and if I could stop smoking I would be 100% better. I know it's doing no good for my health, no good at all. I'm an asthmatic and sometimes I get very very bad asthma attacks and sometimes my chest is very very bad....high blood pressure, all contributes to smoking'

Participant 20, Smoker, Lower SES female, 40-60 years old

Higher SES smokers on the other hand tended to talk of their experiences of much milder symptoms, such as being out of breath when exercising. This also allowed them to identify themselves as 'healthy' (a theme considered in detail in the next section):

I do a lot of swimming and you really notice it then because you do have to control your breathing and stuff, you do actually notice if you've had a few cigarettes the night before'

Participant 5, Smoker, Higher SES male, 20-40 years old

As pointed out by the non-smokers, the smokers in this sample did indeed spend a considerable proportion of their time claiming their invulnerability to health risks. A variety of approaches were used by participants in both SES groups to establish their invulnerability. For example, some smokers challenged the orthodox scientific opinion behind these claims:

'It's like all these black and white things 'smoking is bad for you, it will kill you' but when you look behind what is there, it increases your chances, but it doesn't necessarily mean you will get a smoking related disease, yeah? But obviously statistically you are increasing your chances, therefore it is not a good thing to do'

Participant 18, Smoker, Higher SES male, 40-60 years old

Others used social comparisons with non-smokers who were also ill to illustrate the complexity of the smoking/ill-health link. This 'unpredictability' of the cause and effect (where smokers don't get ill and non-smokers do) was often cited as a reason for doubting the direct link between smoking and ill-health, or at the very least, seeing it as more complex than often portrayed:

'They get thing on the packets now like smoking causes cancer, which I'm sorry, can I swear? It's bullshit! Smoking doesn't cause cancer. It doesn't help it. Cancer is in everyone's body, in everyone is cancer, anything can bring cancer'

out. I know people who don't smoke in their lives and they have got cancer so how can they say it causes it? I think it's a bit OTT'

Participant 31, Smoker, Lower SES male, 40-60 years old

Although the issue of invulnerability to health risks was clearly a salient one for smokers, their discussions were not always internally consistent. Participants often disputed the risks at one point in the conversation, but then also acknowledged the 'unhealthy' side of smoking at another. As such they were engaging in an 'internal' rhetorical dialogue:

'At the end of the day they say that smoking is not healthy for you. Yeah? Now, personally I don't know whether I believe that or not because my nan lived til ninety-two and she was a smoker. You know? My granddad died of lung cancer, never touched a fag in his life. My uncle died of cancer, smoked til the day he died, it was the smoking physically that caused it. My granddad's a smoker, seventy-nine now and still going. Well, he's bit old now, but smoking is not a problem. So I truly feel, that yeah, it is not healthy and it does make your lungs go black and stuff like that'

Participant 23, Smoker, Lower SES female, 20-40 years old

There were also SES trends in health invulnerability. Although some lower SES smokers did dispute the health risks of smoking, higher SES smokers appeared more ready to do so. One way some higher SES smokers did this was to distance themselves from 'at risk' smokers by drawing boundaries between themselves and other 'unhealthy' (invariably 'heavy') smokers. This was particularly easy for the younger age group, such as this female post-graduate aged 26:

'You see people whose fingers are yellow. I just think that's grim, that's horrible. But because I don't see any massive side-effects and because I don't see myself as a heavy smoker, I don't think it will make that much difference. I'm conscious that it's unhealthy. But it's not a huge big deal for me'

Participant 2, Smoker, Higher SES female, 20-40 years old

Another young higher SES smoker pointed out that it is through the fear of being seen as the unhealthy old smoker that he limits his smoking. By doing so he emphasizes his control over smoking:

'If I smoked twenty a day, I'd be like the old bloke [on the park bench]. I'd be sitting there not able to move and I don't know how some people do it really and that's why I'm only an occasional smoker as I do feel the effects of it'

Participant 4, Smoker, Higher SES male, 20-40 years old

In contrast, many lower SES smokers, although aware of their feelings of invincibility tended to be more accepting of the health consequences of smoking. They also tended to evidence a more fatalistic attitude towards preventing them, with the emphasis on the lack of control and powerlessness over whether they become ill:

'I think a lot of it is pot luck, to be honest. Everybody has got most of these things in their bodies, you either get breast cancer or ovarian cancer, it's just maybe the luck of the draw. I mean obviously you are exasperating [sic] a situation if you smoke that if you don't smoke you wouldn't put yourself in, but that's not to say you are not going to get some other form of a terminal disease. It's all swings and roundabouts really'

Participant 35, Smoker, Lower SES male, 40-60 years old

In conclusion, non-smokers from both the lower and higher SES groups made clear links between smokers, death and ill-health. These lay accounts incorporated scientific/media-based knowledge, metaphorical expressions (such as 'killing yourself') as well as their personal experiences of smoking ill-health from their own social group. They also identified an 'it won't happen to me' syndrome of invulnerability amongst smokers in the face of potential health risks. Smokers also made similar conceptual links, however there tended to be differences between the SES groups. Lower SES smokers tended to emphasise the metaphor of death and the smoking-related ill-health of themselves and those around them. They seemed more inclined to accept their vulnerability to the 'health risks' of being a smoker. They also showed a certain sense of powerlessness and fatalism over whether they became ill in the future. In contrast, the higher SES smoking participants tended not to emphasise death or their own personal experiences of smoking ill-health. They were also the group who tended to challenge the 'facts' of smoking-related health and assert their own personal invulnerability by

drawing boundaries between their own smoking identities and those of 'Other' at risk smokers.

8.4 Results: Health consciousness, control and smokers' identities

The previous section focused on how death, ill-health and risk were considered in relation to smoking identities. This final section moves on to consider the creation of smoking identities in relation to lifestyle and behavioural choices, in particular to those labelled 'healthy' and 'unhealthy'. Particular attention is paid to the values and moral discourse surrounding these identities.

Looking first at non-smokers, both lower and higher SES non-smokers had a relatively homogenous understanding, so their accounts are presented together. Overall, the non-smoking participants were very keen to identify smokers as an 'unhealthy' group. As discussed in the Stigmatisation chapter, they often did this identification through aesthetic markers. This look of unhealthiness was not necessarily about obviously having a disease. Rather it was associated by non-smokers with a lack of cleanliness and self-care, and perhaps at a more subliminal level, to dirt and pollution:

'I can pick somebody out that smokes in a group. I could virtually pinpoint all the ones that smoke, definitely, from the ones who don't smoke. [How would you do that?] By the look of them, and if they spoke, even more so, they don't look fresh and healthy, they've got a staleness about them'

Participant 27, Non-Smoker, Higher SES female, 40-60 years old

Several non-smoking participants drew on this negative aesthetic to make positive social comparisons between themselves and smokers in terms of looking healthy. To them, the boundaries between the 'unhealthy' smoker and the 'healthy' non-smoker are literally visible:

'To me they are healthier, they smell nice and they just look cleaner, whereas smokers do look, you know, discoloured a bit'

Participant 25, Non-Smoker, Lower SES female, 20-40 years old

The non-smoking participants also identified themselves as 'healthy' in other ways. For example, they detailed considerable health maintenance routines thereby demonstrating their 'health consciousness':

'I try and discipline myself to eat five pieces of fruit a day, I've got decaffeinated tea and I'm trying to stay off caffeine as well, I'm also trying to drink plenty of water. I do watch my weight, but it's not for health reasons, and I also do try and use that lo-salt as a salt substitute. I've just joined an American company which is quite telling so they're clearly health driven, so I've joined the gym'

Participant 9, Non-Smoker, Higher SES female, 20-40 years old

Even those who did not have extensive health maintenance routines nevertheless felt the need to account for their health behaviour, perhaps reflecting the dominant valuation of health, as this male senior economist in this forties indicates:

'Well, the things I do bad are like binge drinking or whatever, but in general I try to do a little bit of exercise. Being a bloke I'm not that especially keen on fruit and vegetables but I try to make myself have a bit of that from time to time'

Participant 14, Non-Smoker, Higher SES male, 40-60 years old

Implicit in these health maintenance routines are a set of values, in particular discipline achievement and self-control. This is demonstrated by the language used, which includes words such as 'achievement', 'discipline' 'attitude', 'balanced', 'being prepared', 'making choices', 'being in control', 'maintenance', 'watching out', 'vigilance', 'motivation', 'more careful', 'try' 'effort', 'sensible', 'making sure' and 'improvement':

'I have started to swim once a week because I have got a back problem and that's partly connected to that, so I am in the sort of process of trying to monitor and improve and I think that is a good positive attitude to have, monitor and attempt to maintain and improve as opposed to somebody who becomes slobby, slothy, lazy'

Participant 33, Non-Smoker, Lower SES, male, 20-40 years old

Some non-smokers also made it explicit that they valued health in and of itself:

'Health is something that I value enormously, want to make the most of, capitalize as much as possible, do things within reason to make that happen. I just value health, I just think it is the key to your life really. It would be top priority for me'

Participant 28, Non-Smoker, Higher SES female, 40-60 years old

Non-smokers also drew boundaries, in the form of positive social comparisons, between their 'healthy' (and thus 'good') behaviour and the 'unhealthy' (and thus 'bad') behaviour of smokers:

'I think we all respect ourselves. That's not to say that smoker don't respect themselves, but we physically respect ourselves that we want to keep ourselves in as good a condition as possible. It's just different lifestyles, umm, my family and friends for whatever reason seem to take physical health more seriously and are more active in trying to maintain that and the other set [of smoking family] are at the other end of the spectrum'

Participant 12, Non-Smoker, Lower SES male, 20-40 years old

This identification of smokers as 'unhealthy' also allowed a moral position to be taken as regards their 'unhealthy' behaviour. In particular, this took the form of accusations of selfishness in failing to perceive or act on the risks or continuing to smoke whilst ill. Some non-smoking participants felt smokers were selfish with respect to the wider community or the NHS, given the cost of treatment. Others thought they were selfish towards others that they knew. Lower SES non-smokers were particularly keen to identify the smoker as selfish:

'What I think is being selfish is like, it's been in the press recently, people suing tobacco firms etc. Everyone knows, from small four, five year old children to old-age pensioners, everyone near enough knows the risk of smoking. If you are going to go ahead, take that risk up, it is your risk. You know what is going to happen at the end of it. Even in hospital they will still have a fag and go out and have a cigarette, I think that is really really selfish'

Participant 39, Non-Smoker, Lower SES female, 40-60 years old

So, how do smokers construct their social identity in response to this identification of themselves as 'unhealthy' and the attendant negative moral and value associations that accompany this?

There appear to be socio-economic differences between the way in which higher and lower SES smokers construct their identity in response to health. Overall, the higher SES smokers were not keen to relinquish their image as healthy, despite their status as smokers. They employed a variety of social identity techniques to defend their healthy identity. The following higher SES smoker explained clearly why there is an incompatibility between the image of a smoker and the image of a healthy person, which is why this identity work was so pronounced. It is interesting to note that she was not saying that smokers can't be healthy, just that the image of health and smoking don't go together:

'All that fitness stuff, the gym, the football, the swimming, that all says 'non-smoking' to me, it's not really kosher to smoke going to the gym. Cross country, marathon running, jogging, it just doesn't fit the image'

Participant 6, Smoker, Higher SES female, 20-40 years old

One way in which they did this was simply to avoid making social comparisons with 'healthier' non-smokers. A second strategy was to challenge directly the idea that smokers can't be healthy. They did this by introducing other dimensions of health on which non-smokers might unfavourably compare. For example, several higher SES smokers pointed out that non-smokers might engage in other health-compromising behaviours which mitigate their claim to be 'healthy':

'I know non-smokers, completely paranoid non-smokers who'll stuff their face with junk, you know, they treat their body like a toilet in every other respect of their lives, except that one. Yeah, you're still going to die!'

Participant 4, Smoker, Higher SES male, 20-40 years old

Higher SES smokers were also very keen to demonstrate their health consciousness, also detailing quite extensive health maintenance regimes similar to those of the non-smokers. Again, the underlying message was that it is possible to have a healthy identity and be a smoker, as this IT consultant in his mid-thirties was at pains to point out:

'I do bizarre things like when I go for a bike ride, I'll stop, have a cigarette and get back on the bike and again that's where you get this non-smoker view, 'what on earth are you doing, you're doing something that is healthy and good for you and then at the same time you've having a cigarette'. I used to go to the gym and people could never understand why I would want a cigarette on the way there and as soon as I came out, I would have a cigarette as well. But there's no correlation in terms of I don't do things because I smoke'

Participant 18, Smoker, Higher SES male, 40-60 years old

Several higher SES smokers mentioned that they specifically engage in health behaviours which they think mitigate the effect of smoking. For example, some smokers mentioned taking vitamins or aspirin to counteract the effects of smoking, thus this young postgraduate female told us:

'I was out last night and I'm conscious that it's not healthy and therefore, like this morning I made sure I took my vitamins, just because you know, being out.'

Participant 2, Smoker, Higher SES female, 20-40 years old

The metaphor of pollution is key to understanding this idea of limiting the damage. Higher SES smokers often claimed that by engaging in health behaviours, they were limiting the polluting effects of smoking, by 'balancing', 'cleansing', 'purifying' or 'detoxing' their bodies:

'For me personally, I find a balance between smoking and exercise, I actually think that doing a bit of both is not such a bad thing. If you are just sitting in a room smoking, not taking exercise, then you are more likely to suffer the effects, like the symptoms are clots and stuff like that. I think exercise actually does help to clean your lungs out, also by sweating you are sweating a lot of impurities'

Participant 5, Smoker, Higher SES female, 20-40 years old

The effect of detailing these health maintenance routines is to show that despite being smokers, these higher SES individuals still nevertheless exhibit the same values of self-control, discipline and responsibility as non-smokers (and other middle-class people). This is also emphasised in their accounts of quitting, which is described as getting smoking 'under control', often according to a timetable, such as when they feel 'unhealthy' or perhaps a milestone such as turning thirty:

'I think maybe it's starting to build a family or if you buy your own home, you start worrying more about your health and the fact it's not just about you, it's about your children. I think 16-30, as I say, after that you, sort of, should consider your children, changing lifestyle a little bit'

Participant 2, Smoker, Higher SES female, 20-40 years old

Quitting smoking was also clearly associated by these higher SES smokers with moving towards a healthier lifestyle. Several participants reported that they were more likely to quit when they were going through 'healthy' phases. The way in which these 'healthy' phases were detailed was reminiscent of the discussion of detoxification to cleanse the body of the pollution of smoking:

'I clearly feel a lot better when I'm not smoking, but I guess the question-mark was that part of the reason I feel better when I'm not smoking is because I'm doing all these other things, I eat better, I'm swimming regularly, I cycle everywhere, I don't have a car, I cycle all over, it's a package deal'

Participant 4, Smoker, Higher SES male, 20-40 years old

Finally, higher SES smokers also distanced themselves from the unhealthy identity of the smoker by identifying 'Other' smokers who are unhealthier than themselves, particularly the 'old' and the 'heavy' smoker. These types of unhealthy smoker were contrasted with the social or occasional smoker, with whom many higher SES smokers identified. Drawing these boundaries between types of smokers also allowed higher SES smokers to make positive social comparisons:

'If I smoked 20 a day, I'd be like the old bloke on a park bench. I'd be sitting there not able to move, and I don't know how some people do it really and that's why I'm only an occasional smoker'

Participant 5, Smoker, Higher SES male, 20-40 years old

In summary, the higher SES smoking participants tended to challenge the idea that smoking and healthy identities are incompatible. This smoker summed up the defiant attitude:

'I think it has just become one of those things that is an easy target to have a go at somebody just because they smoke. I mean if you looked at my lifestyle, it is probably healthier, I mean other than smoking. I have my five fruit and veg a day, I go to the gym three times a week, I'm probably a damn sight healthier than somebody who doesn't smoke but sits there all day shovelling chips and gin down their throat all day.'

Participant 37, Smoker, Higher SES female, 40-60 years old

The understanding of healthy identity for lower SES smokers was somewhat, although not completely, different compared with that of the higher SES smokers.

Firstly, unlike the higher SES smokers, the majority of lower SES smokers did identify non-smokers as healthier, cleaner and having a better appearance. In doing so, they made negative social comparisons which did not benefit their own social identity:

'The way I'd look at non-smokers [when giving up] for encouragement and I just think they look so much nicer, you usually see these people with either eating a bit of fruit or walking down to the gym, whereas with a smoker, they are trying to smoke, a different image altogether, and I think a non-smoker is much more attractive. I don't just mean nicer to look at, it's nicer to see'

Participant 22, Smoker, Lower SES female, 20-40 years old

There was a sub-group of lower SES smokers who detailed quite similar health maintenance routines to the higher SES smokers. They were all young single mums who wanted to quit and had tried numerous times. They connected exercise and living a healthier lifestyle with quitting, however, they were often concerned about whether this was practical for them personally, given their life stress:

'I mean, I've been keeping really fit for the last god knows how many years and I think that does stand you in good stead and say if somebody didn't do exercise and they were smoking, then they would be affected a lot more...from people I have seen, I have got a lot of energy, I am motivated and all that, whereas other people I know, they are happy to come home from whatever they are doing, sit down and just smoke for the night whereas I would try and get to the gym or do something'

Participant 22, Smoker, Lower SES female, 20-40 years old

However, apart from this minority, most lower SES smokers tended not to emphasise that their lifestyle was healthy and did not seem as concerned to appear overly health conscious:

Yesterday I had a free day and I sat there, I didn't really go out. I sat there, had a couple of beers, and I just kept smoking, smoking all the time, take one out and put one in, put one in two minutes later, no longer than that. I must have smoked 300 fags yesterday'

Participant 7, Smoker, Lower SES male, 20-40 years old

Some lower SES smokers also made negative social comparisons between themselves and non-smokers:

'I mean maybe cos I smoke I get out of breath, maybe if I was to run, not that I have to run for a bus no more, but if I have to run for a bus I am a bit [panting noise]. Now that I don't go to the gym and I don't go to aerobics, I don't do no exercise, I would say probably a part of it will be cos of smoking, because my friend who gave up, she says she can run, she doesn't get out of breath so quick because she's not smoking'

Participant 23, Lower SES female, 20-40 years old

Not only did lower SES smokers seem less concerned with defending their healthy identity, several also maintained that they prioritised other alternative values to health, particularly 'enjoying life' which is seen as a rationale for continuing to smoke:

'I'd sooner have a shot at life and enjoy myself than live a long one and be boring...I know I probably won't live longer, I know that because I do smoke too much. You know you're going to cop it one time or another but I'd sooner live a short life and make it as exciting as possible than live a longer one and be miserable'

Participant 7, Smoker, Lower SES male, 20-40 years old

However, although overall the lower SES smokers seemed much less concerned with health consciousness and detailing health maintenance routines, many of them still nevertheless identified themselves as healthy due to the fact that they are still active:

'Well, I'm healthy at the moment, even though I smoke, I feel healthy. That's health to me, cos I can get up every morning even though I smoke, I can still get up on my feet, nothing is really affecting my body, I feel strong, I feel healthy'

Participant 21, Smoker, Lower SES female, 40-60 years old

To summarise this section, both lower and higher SES non-smokers were concerned to present themselves as 'healthy'. Smokers were deemed 'unhealthy' through the marker of a negative aesthetic appearance, which was associated with looking unclean. The non-smoking participants also detailed quite extensive health maintenance routines which reflected the core values of self-discipline and personal responsibility. They used these to draw moral boundaries between their own 'healthy' behaviour and that of smokers who are labelled 'unhealthy' and thus selfish, out of control and irresponsible.

There were differences in emphasis between the lower and higher SES smokers in their understandings of their smoking in relation to lifestyle. Higher SES smoking participants tended to identify themselves as 'healthy' using a number of strategies. For example, they avoided unfavourable social comparisons with non-smokers on the basis of health. Many also directly challenged the idea that smokers can't be 'healthy'. The higher SES smokers also detailed considerable health maintenance routines similar to those of the non-smokers. Some behaviour was a response to their smoking, for example, exercising to help clear the lungs. They also distanced themselves from the identity of the 'unhealthy' smoker by identifying 'Others', namely heavy smokers, who are unhealthier than themselves. 'Social' or 'occasional' smokers were exempt from the negative association of being seen as unhealthy.

The lower SES smokers in this sample, on the other hand, did not tend to identify their lifestyle as healthy. They also frequently made negative social comparisons between themselves and non-smokers. Several lower SES smokers also mentioned that they prioritise alternative values such as 'enjoying life'. Nevertheless, many lower SES smokers considered themselves to have good health on the basis that they were still active. A small sub-group of lower SES smokers had a similar notion of health

consciousness to the non-smokers and were focused on quitting smoking, though they felt constrained from achieving this goal by their far from ideal life circumstances.

8.5 Discussion

This discussion covers several main areas. Firstly, the dominance of the health discourse in relation to smoking in these results, reflecting a wider symbolic valuation of health prevalent in Western societies (Crawford, 1994), is considered. Secondly, the SES trends in definitions of generic health are discussed. Thirdly, the understandings of risk and the notion of smoking as paradoxical are explored. Finally, the way in which participants from the different SES groups understood smoking in relation to lifestyle is considered, particularly in relation to the ideological context of the 'duty to be healthy' (Crawford, 1994). The potential implications of these results for health promotion are considered throughout.

8.5.1 *The socio-cultural valuation of health in late modernity*

There is much evidence, from the interview results, that health is a dominant discourse concerning smoking. It emerged not just as a specific topic within the interviews, but as a continuous narrative thread throughout. This discourse encompassed many different types of material, from the scientific assessments of health risk, to metaphors of death, dirt and pollution, to personal stories about the experience of smoking ill-health. The issue of health had to be negotiated continuously by the smoker, whether or not it was actually the point of discussion at any one time. The emphasis on health/illness in the interviews undoubtedly reflects the medicalization of smoking that was suggested theoretically in Chapter One and Two (also see Penn, 1998) and corroborated through the identification of a lay biomedical addiction model amongst participants in Chapter Seven. This dominance is an ideological one. Crawford has pointed out that the concept

of health is absolutely central to modern late 20th and early 21st century identity (Crawford, 1985; 1994). Health signifies certain desirable core values in society and thus endows power to social groups that are seen to possess it (Crawford, 1994). The consequence of this is more than 'health consciousness', it is 'healthism'; discrimination between social groups based on 'health' as the supreme value (Crawford, 1980; Lupton, 1995; Petersen and Lupton, 1996). The valuation of 'health' and the 'duty to be healthy' therefore represents a major, and ideologically significant, socio-cultural context in which smokers have to both 'make sense' of their own smoking and manage their negative social identity as 'unhealthy'.

This context also presents a methodological problem for the interviewer. Given this valuation of health, and 'healthy people' at an ideological level, the interviewer may be perceived as a representative of the health and biomedical project, even if attempts are made to the contrary (Laurier, 1999). Laurier (1999) has argued that given that the topic of smoking is highly charged, interviewing about smoking always represents 'a problematic relation to health for the smoker who is called to account' (p.197). It is interesting to consider, however that the extent to which working and middle-class groups feel 'called to account' over health may differ as these results illustrate.

8.5.2 Generic definitions of health

The results showed that the definition of health tended to differ between SES groups in this sample. Previous research has suggested that multiple conceptualisations of the term 'health' exist (Herzlich, 1973; Blaxter, 1990). Furthermore, these differ according to the material/cultural context of their production, such as between different class groups (d'Houtard and Field, 1984) or the manual/intellectual divide (Pierret, 1983). The most common finding has been that lower SES individuals define health in functional terms, as an absence of illness and the ability to do things (Blaxter, 1990;

d'Houtard and Field, 1984; Pierret, 1983). This was corroborated here. The lower SES participants in this sample tended to use a functional definition of health. However, d'Houtard and Field (1984) and Pierret (1983) also found that the middle-classes defined health primarily in terms of enhancement, as well-being. This was not the case in this sample, where it was found that the concept tended to be drawn on equally by individuals from all SES groups to explain health. Furthermore, a third distinguishing classification was identified here, particularly amongst higher SES participants; health as behaviour itself. Health as behaviour was not simply a description of what healthy people might do. Rather when asked to define health, it was defined as participation in a series of lifestyle activities, namely the triad of not-smoking, diet and exercise.

It is not surprising that definitions of health have changed in the last twenty or thirty years since much of the research into lay concepts of health was conducted. All social psychological and sociological research, particularly into lay accounts, has a historic dimension. Indeed, linking these concepts with the context of production which changes over time makes this inevitable. For example, Herzlich's research reflected the movement from a rural to an urban way of life in France, just as Pierret's research reflected a division between manual and intellectual work in a given context. However, the shift identified here may be quite significant. It appears that the dominant concept of 'health as well-being' has rolled out across social classes to be found equally in their discourse. Health as well-being is now an aspiration for all.

In its place, a new dominant definition of health, as behaviour itself, has emerged. This suggests that the process of the valuation of health that Crawford identified in the middle classes, whereby healthy behaviour stood for other social values has moved on; the behaviours have become the value itself. In contemporary thinking, health IS healthy behaviour. One implication of this is that healthy individuals are located by the

things that they do, not their internal bodily states. This shifts the locus of health to an external position rather than an internal one, for these behaviours can be observed and judged by others. As discussed in Chapter Three, Crawford has argued that the socio-cultural valuation of health above other values ('healthism') contributes to a bifurcated divide in society, between the healthy, who are socially valued and the 'unhealthy', who are not. If 'health' is defined aspirationally as a state of well-being, then it is hard to find people, in a health conscious nation, who openly disagree with this valuation. If, however, the definition has moved on so that health is defined directly as behaviour itself, then this once again boosts the social identity of the middle-classes who are the most likely to perform these behaviours. The evidence of their superior healthiness, and as Crawford would have it, their ideological fitness to rule, is demonstrated by the health behaviours which they perform. This also makes the identification of the 'Unhealthy Other' much easier; one can simply judge external health behaviours.

It is too simplistic to say that this understanding of health as behaviour is solely the preserve of the middle-classes. Rather is it a dominant understanding which favours them, but also one which other groups are also acutely aware, which is why the lower SES smokers do refer to it. There are potential consequences of this differential conceptualisation however, which may perpetuate smoking inequalities. One of the key reasons smokers are exhorted to give up smoking is because it is 'unhealthy' or 'for the sake of their health'. Indeed 'health' is identified as the prime motivation by smokers wishing to quit (ONS, 1999). However, using a functional definition of health, many lower SES smokers defined themselves as healthy on the basis of their continued participation in life. This leaves lower SES smokers at risk of not perceiving smoking to affect their health until thirty or forty years into a smoking career when the health effects are probably irreversible and their behaviour entrenched (Calnan, 1991). Middle-

class smokers who deem smoking to be unhealthy per se are much more likely to be receptive to the 'health' message. It fits exactly with their conceptualisation of smoking as the very antithesis of health. To carry on smoking is literally to be unhealthy, even if no symptoms present themselves. Thus for middle-class smokers, the message of 'quit for your health' has an immediate meaning, requiring immediate action if one is to be classified as healthy. The implication of these different understandings for health promotion is explored further in Chapter Ten.

8.5.3 *Perceptions of risk and the paradox of smoking*

The understandings of death, disease and risk by participants from different SES and smoking status groups can also be seen to reflect their social identities. The US Surgeon General (1990) stated that 'smoking represents the most extensively documented cause of disease ever investigated in the history of biomedical research.' Much of this health knowledge is gleaned from the mass media through 'experts'. However, it is not absorbed uncritically (Hall, 1980). Rather mass media messages are accepted, challenged and negotiated by ordinary people, and, importantly, benchmarked against their own tangible experiences in their every-day lives.

The perceptions of 'risk' in relation to feelings of invulnerability in the interviews is a good case in point. This perception of invulnerability to risk is often termed in the psychological literature a 'not me' or 'optimistic bias' (Weinstein, 1982; 1987). Much debate has focused on whether such a bias constitutes faulty cognitive processing (by comparing perceptions of risk with 'actual' risk), or in fact, represents a way of comprehending risks which 'makes sense' to lay people within the context of their emotional and social lives (Radley, 1998).

The smokers in this sample showed a highly sophisticated and complex understanding of risk evaluations which they used to illustrate and defend their sense of invulnerability. One key way they did this is to point to group variability by highlighting the complexity of the cause and effect of smoking-related illness. By drawing, for example, on counter-examples such as the 'nan who lived to ninety-two who was a smoker' they show awareness that many of the 'black and white' messages offered by health promotion that smoking automatically equals an early death are oversimplistic. They simply don't bench-mark successfully against their own personal experiences. It is also identity protective for them to perceive themselves as not 'at risk' given the social stigmatisation of those who engage in risky behaviours.

In terms of health promotion, this presents a problem. If smokers tend not to perceive themselves as 'at risk', this may impact their motivation to quit. It has been argued that in fact it is misguided to focus on risk so extensively, given that, as the review in Chapter Two showed, models based on the Knowledge, Attitudes and Beliefs paradigm have mainly failed to predict quitting (e.g. van de Plight, 1998). However, it is arguable that, although the focus on risk may be too narrow, it is equally misguided to ignore it, given its ideological dominance. Participants in these interviews, when left to spontaneously produce images of smokers, centred on health and health risk as a key dimension. It seems to me a pre-requisite of behaviour change in smoking for smokers to feel at risk at some level, whether it be from imminent health problems or those in the future. However, this is clearly not enough; simple 'at risk' messages are seen by the smokers in this sample as exactly that; simplistic and are often discounted.

Something which is not successfully tapped by quantitative questionnaire-style research on which the KAPB is based is that the construction of risks is often inherently contradictory (Campbell, 1998). The smokers in this sample often presented a complex

and contradictory discourse surrounding health risks, for example, at one moment disputing the statistical risk of smoking, at another wholeheartedly accepting its designation as the epitome of unhealthiness. Another instance of this complexity was that lower SES smoking participants tended to weigh 'enjoying life' against the health risks of smoking. The implication was that to enjoy life in the here and now may simply be incompatible with valuing future health and that this was a valid judgement call to make. The perceptions of health risk in these interviews often reflected an 'internal' rhetorical dialogue rather than a consistent position in line with Billig's thesis (Billig, 1987).

Indeed, it has been argued that smoking is an inherently paradoxical behaviour. Klein has argued that is intrinsic to the desire of cigarettes that they are dangerous (Klein, 1993). He argues that beneath the current healthist moral discourse of public health professionals and governments is something they cannot comprehend and therefore try to suppress; that the 'sublime' paradoxical attraction of cigarettes is that they can cause death. Thus he tells us 'cigarettes are not positively beautiful, but they are sublime by virtue of their charming power to propose what Kant would call 'a negative pleasure'; a darkly beautiful, inevitably painful pleasure that arises from some intimation of eternity; the taste of infinity in a cigarette resides precisely in the 'bad' taste the smoker quickly learns to love' (p.2)

One can certainly see touches of the intimations of mortality smoking offers in the comments of the young middle-class smokers in this sample. For example, one higher SES smoker reported feeling more like smoking in response to being told it is bad for you. Another felt 'in control' of her destiny, taking her life into her own hands, whilst smoking. This echoes the findings of Denscombe (2001) who found that adolescents understand taking up smoking as a marker of personal decision-making and as such,

representative of their control and autonomy over their own destiny. One need not agree with Klein's conclusion, that 'the more vigorously government denounces the danger of cigarettes, the more it serves to incite people to go on smoking' (p.188). The young middle-class smokers in this sample, who perhaps like all young generations have a sense of immortality, are exactly those same smokers who research shows are the ones who will have quit by middle-age. However, he makes a good point which is almost entirely missed by the current obsession with 'risk' within health promotion: pleasure and risk are not mutually exclusive factors. What else is hedonism if not the pleasure in doing forbidden things?

The internal rhetorical dialogue of the smokers in these interviews often contained the discourses of risk and pleasure simultaneously in a state of paradox. The risk discourse was clearly dominant and the expression of pleasure by contrast was only hinted at by a minority of interviewees. However, this may be because the expression of pleasure is not seen as politically correct as it perhaps flies in the face of the dominant health messages concerning the risks of smoking. The way in which health promotion might acknowledge this paradox is explored in Chapter Ten.

8.5.4 *The creation of healthy identities and smoking identities in relation to class*

Crawford's cultural thesis is essentially one of identity work; the symbolic identification of the 'Unhealthy Other' to the social benefit of the 'healthy'. There is much in these results which suggests that this process occurs in the context of smoking. The non-smoking participants from both SES groups in this sample showed their desire to identify themselves as healthy and smokers as the 'Unhealthy Other' in numerous ways. Firstly, they paid much attention to extensively detailing smoking health risks and diseases. This identifies the smoker as strongly associated with poor health. Secondly, they detailed considerable health maintenance routines, which were infused with the

language of 'effort', 'discipline' and being consciously 'in control'. This supports Crawford's argument that, at a socio-cultural level, 'health' has come to symbolise other socially accepted values, most notably discipline, self-control and personal responsibility. The non-smokers thus label themselves as the health-conscious individuals who embody these other values. Thirdly, many non-smoking participants thought that one could draw these boundaries on the basis of looks alone, not so much through the symptoms of disease, but through smokers' negative aesthetic appearance, which is deemed 'unclean'.

This use of a pollution metaphor was discussed in the Stigmatisation chapter. It was argued that it constitutes the basis of an emotive and symbolic stigmatisation of the smoker as a 'polluter'. Here, it is entwined into the health discourse. As Douglas (1967) suggests, lack of purity is a marker of risk, in this instance marking out the smoker as at risk to both themselves and others. They are thus morally censured. Smokers were labelled 'selfish' by the non-smoking participants through their lack of responsibility to their family and the wider community. For non-smokers, the benefit of this labelling is clear: they are the 'good' ones who embody the desired social values, and the attendant social status that this brings.

Crawford theorises that 'healthism' is driven by the middle-class classes. However, the results here show that the lower SES non-smokers tended to exhibit an almost identical health consciousness to that of higher SES non-smokers, and indeed often seemed keener to make moral judgements about 'selfish' smokers on the basis of this. There may be several potential reasons for this. Firstly, as argued in the section on generic health, the valuation of health is so dominant that it has permeated beyond its original class boundaries to become a mainstream socio-cultural given. Secondly, given that smoking rates are still reasonably high in working-class communities, non-smoking

lower SES individuals are likely to have had to take a stand and define their identity as a non-smoker. Drawing on the mainstream valuation of 'health' is an easy way to do this. Finally, a moral discourse was highly salient amongst the lower SES non-smokers. They seemed less concerned with political correctness and keener to point out their own 'responsibility' in not smoking. Crawford theorises that where the boundaries might be most blurred, the identity work will be the greatest. Thus it makes sense that lower SES individuals would work harder to distinguish themselves from their 'unhealthy' contemporaries to avoid being tarred with the same brush. It also affords them an opportunity for social superiority within their own group. People who are not health conscious, or appear not to value health, may therefore be increasingly marginalised within working-class groups themselves. It may be that in the future, smoking becomes a marker of the 'under-class' rather than the 'working-class'.

There appeared to be considerable SES differences between the lower and higher smokers in response to their designation as the 'Unhealthy Other'. The higher SES smoking participants engaged in considerable identity work to preserve their healthy identity along with their smoking status. Some simply avoided making social comparisons with smokers on the basis of health, an area in which they were unlikely to be favourably compared. Others were more challenging; for example, pointing out the unfairness of using smoking as *the* pre-eminent marker of unhealthiness when non-smokers also engage in unhealthy behaviours and suffer serious disease. They also tended to distance themselves from the identity of the unhealthy smoker by splitting the smokers group into categories and placing themselves as a member of a 'superior' smokers group. In particular they identified 'heavy' or 'old' smokers as unhealthy rather than those who are 'social' or 'occasional' smokers. This represents a process of

differentiation from within the at risk group: the 'Other' simply finds 'an-Other' who is more at risk than themselves (Brown, 2000).

Higher SES smokers also displayed their healthy identities by detailing health maintenance routines similar to those of the non-smokers. Indeed, the language of these disciplined routines was very much reminiscent of de-toxification and cleansing regimens. Several participants articulated the idea, for example, that they were cleansing their body of the smoke toxins through exercise. This, at a conscious or unconscious level, offers a challenge to the idea that smokers are polluted by their habit: the higher SES smokers are attempting to re-create their status as 'pure' (and thus socially valued) through the performance of 'purifying' health behaviours.

The overwhelming message of the higher SES smokers was that it is possible to be both identified as healthy and a smoker. This identity work is so pronounced precisely because they are perceived, even by smokers themselves, to be fundamentally incompatible identities. In fact, this incompatibility may well work to their advantage in terms of quitting. Giving up smoking brings the middle-class social identity into line with itself and represents a move towards coherence. The results here suggest smoking is now conceptualised as an intrinsic part of a lifestyle 'package' of healthy behaviours which have come to define health itself. The epidemiological evidence presented in Chapter One showed that higher SES smokers are signing up for this package in ever increasing numbers as their smoking rates continue to fall.

The lower SES smokers in this sample were less concerned to identify themselves as 'healthy'. They tended to fall into two distinct camps; a small sub-set of single mothers who were health conscious but felt themselves constrained by circumstance to quit, and the majority, who were relatively accepting of their designation as the 'Unhealthy Other'. One example of this acceptance was the 'fatalism' which many lower SES

smokers evidenced in the face of the health risks. They were inclined to accept their vulnerability as 'pot luck'. This corroborates other research which has found lower SES individuals tend to have a more fatalistic attitude towards health in general (Calnan, 1989) and smoking-related ill-health in particular (Lewis et al., 1989; Chamberlain & O'Neill, 1998).

Little attention has focused in the SIT paradigm on the consequences in terms of group self-esteem of accepting such negative derogation (Brown, 2000). It has tended to be assumed that a group with a negative social identity will always work hard to bolster their self-esteem. However, there are signs here that some (though not all) lower SES smokers may simply accept this negative identification and indeed internalise it, shown by the fact that a majority of lower SES smokers identified non-smokers as healthier, cleaner and having a better appearance than smokers, their own identity. This does not mean that they necessarily consider themselves unhealthy in terms of being ill. Many also identified themselves as functionally healthy. However, that they are aware that in the social hierarchy of health, they are somewhat near the bottom. The consequences for this, in terms of health promotion, are considered in Chapter Ten.

8.6 Conclusion

Health is a primary discourse in relation to smoking identities. This reflects the bio-medical conceptualisation of smoking outlined in Chapter Two, which itself reflects the wider symbolic context of the valuation of 'health' and the 'healthy' in contemporary society (Crawford, 1994). Definitions of health, however, may be changing. The lower SES participants in this sample tend still to prioritise a functional definition of health-as-not-ill, but they share equally the idea of health as well-being with the higher SES participants. A new definition of health as behaviour is being championed by higher

SES groups which externalises health and thus allows the identification of the 'unhealthy' by their failure to perform 'health behaviours'.

Smokers are identified, to use the terminology of Crawford, as the 'Unhealthy Other' by non-smokers. Non-smokers benefit from this social boundary-drawing by identifying themselves as the 'healthy' (responsible, self-disciplined and in control) members of society. The lower SES non-smokers in these interviews tended to be even more judgemental than the higher SES non-smokers, suggesting strong identity work where the boundaries are most blurred.

For higher SES smokers, their designation as the 'Unhealthy Other' is a threatening one, which they try to defend. They stress the complexity of cause and effect within disease, the fact that non-smokers can also become ill, and identify themselves as members of a 'superior' smokers group. They also emphasise their health consciousness, particularly their de-toxification behaviour, in the face of being identified as 'polluted'. However, the difficulty of reconciling their healthy and smoking identities may work to their advantage; giving up smoking offers a highly motivational way to make their social identities more congruent.

Lower SES smokers, on the other hand, appear less concerned to identify themselves as health conscious. Coupled with the negative comparisons they make between themselves and 'healthy' non-smokers, this suggests an internalisation of their status as the 'Unhealthy Other'. They also exhibit a fatalism and powerlessness in relation to the health effects of smoking, indicating a passive acceptance of their status as 'at risk'. For them, simple health messages to stop smoking may not have the resonance at an identity level that they do for higher SES smokers.

CHAPTER NINE:

RESULTS AND DISCUSSION: Q SORT OF SMOKING IDENTITIES

9.1 Introduction

The Q-sort study was conceptualised as a complementary study to the interview study which would extend the thesis findings. The aim of a Q-sort is to separate and clarify accounts of a topic, in this instance, the creation of smoking identities particularly amongst different class groups. The rationale behind the methodological choice of a Q-sort and the details of the procedure has been outlined already in Chapter Five. There are two important things to note. Firstly, the Q-sort was conducted after the interviews. The Q-sort items therefore reflect the topics which emerged as salient. Secondly, unlike in the interviews, the sample of the Q-sort was smokers only from both lower and higher SES groups. Non-smokers were not included. This allows more focus on smoking identities from the perspective of the smoker. At a practical level, it also proved difficult to create statements of self-identity concerning smoking that would be relevant for both smokers and non-smokers. Thus the Q-sort is a complementary piece of research rather than one that simply aims to replicate the interviews through a different methodology.

9.2 Results: Model selection and factor interpretation

The standard rule is that factors should only be considered for interpreted if the eigenvalue is greater than 1, unless there is a particular theoretical reason for examining it (Brown, 1980). An eigenvalue greater than 1 means that at least one Q-sort loads significantly onto that factor. Another rule of thumb, not just in Q methodology but in all statistical modelling, is that models should be parsimonious. In other words, they should reduce complexity, yet explain as much variance as possible. In the PQ Method

programme, a maximum of eight factors can be rotated. When an eight factor model was run, it revealed that all factors had a loading of more than one. However, it is not necessarily desirable to have an arbitrary eight factor model simply because that is the limit set by PQMethod. It was decided to run several models, a five, six and seven factor model and compare their explained variance. A five factor only explained 44% of the variance, whereas the six factor model explained 52% of the variance, an increase of 8%. A seven factor model only explained an additional 4% for the corresponding drop in parsimony. It was therefore concluded that that a six factor model balanced parsimony with maximum variance the best. The eigenvalues (calculated as variance x no of statements) and the variance for the six-factor model are shown at the bottom of Table 4.1 below.

Table 4.1 also shows the results of the Q-sort participant loadings for the six-factor model. Each loading is expressed as a correlation, either negative or positive. The interest here is in whether the sort loads significantly at $p < 0.01$ (the standard statistical significance level). This would indicate that one would only expect this pattern by chance less than 1 in 100 times. The 0.01 significance level in this analysis was a loading of 0.31. However, it was decided to make the level even more stringent, requiring a loading of 0.4 (hand-flagged rather than flagged by the programme). This was to maximise the number of loading participants as well as maximising the variance explained. A sort is excluded from the analysis if it loads significantly onto more than one factor (known as a 'confounding sort'). A lower loading (of 0.31) is likely to produce more confounding sorts. In this analysis, at a loading of 0.4 with a six factor model, four Q-sorts were non-significant i.e. they didn't load onto any factor. Six sorts were confounded and dropped from the analysis. This meant that the vast majority of sorts (54) were utilised to create the factors and factor arrays.

A sort that loads significantly (at 0.4 or higher in this instance) is called an 'exemplar'.

It is literally an exemplary sort for this factor. In this analysis, the first factor has 20 exemplars, the second factor has 11, the third factor 7, the fourth 5, the fifth factor has 6 and the sixth factor has three exemplars.

Qsort number	Participant†	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6
1	F hses 33	-0.14	0.42*	0.24	0.28	0.39	0.28
2	M hses 22	0.41*	0.30	-0.16	-0.87	0.29	-0.24
3	F hses 50	0.05	0.33	-0.01	0.04	0.77*	-0.11
4	M hses 27	0.22	0.08	0.14	0.60*	0.21	0.11
5	M hses 28	0.51*	0.36	-0.07	0.24	0.34	-0.08
6	F hses 27	0.01	0.10	-0.42*	0.23	-0.01	-0.02
7	F hses 21	0.63*	0.27	-0.24	0.05	0.15	0.12
8	M hses 25	0.01	-0.13	0.28	0.02	0.52*	0.27
9	M hses 31	0.18	0.53*	0.14	0.16	0.26	-0.26
10	F hses 28	0.09	0.51*	-0.34	0.02	0.06	0.16
11 n.s.	M hses 21	0.01	0.38	0.33	0.05	-0.03	-0.12
12	M lses 51	0.06	0.26	-0.08	0.04	0.76*	-0.04
13 conf.	M lses 28	-0.25	0.14	0.47	0.40	-0.16	-0.11
14	F hses 28	0.20	0.19	0.55*	0.16	0.11	0.06
15	M hses 24	0.53*	0.10	0.07	0.16	0.32	-0.06
16	F lses 27	-0.05	0.54*	0.07	0.30	-0.14	0.00
17	M hses 28	-0.32	0.44*	0.26	0.11	0.12	0.39
18	F hses 21	-0.06	0.76*	0.11	-0.17	-0.18	-0.12
19	M hses 22	0.24	0.33	-0.15	0.15	0.26	0.57*
20	F lses 21	0.05	0.56*	0.34	0.13	0.35	-0.29
21	F hses 21	0.04	0.65*	0.01	0.16	0.00	0.18
22	F lses 20	-0.08	0.52*	-0.12	-0.05	0.05	0.19
23	F lses 20	0.29	0.57*	-0.37	10.25	0.04	-0.05
24	F lses 21	-0.09	0.69*	0.00	-0.39	0.19	0.16
25	F lses 21	0.78*	0.11	0.04	-0.05	0.08	-0.01
26	M hses 25	-0.23	0.13	0.53*	-0.02	-0.06	0.22
27	F hses 25	-0.00	0.56*	0.15	-0.00	0.27	0.11
28 conf.	M lses 59	0.46	-0.15	0.55	0.10	0.10	0.18
29	F lses 21	0.78*	-0.02	0.18	0.01	-0.12	-0.05
30	M lses 24	0.59*	0.20	0.23	0.07	0.06	-0.18
31	M lses 34	0.10	0.10	0.02	0.01	-0.10	0.65*
32	M lses 24	0.64*	0.33	0.09	-0.23	0.11	-0.24
33	F lses 34	0.71*	0.05	-0.03	0.02	-0.02	0.09
34 n.s.	F hses 46	0.18	0.31	0.38	0.35	0.14	0.02
35	F hses 27	0.35	0.42*	0.32	-0.21	0.30	-0.17
36	F hses 44	0.44	-0.06	0.15	0.29	0.29	-0.39
37	F lses 31	0.74*	0.09	0.04	0.04	0.04	-0.83
38	M lses 60	0.70*	-0.26	-0.024	-0.08	0.21	0.01
39	F lses 23	-0.08	0.06	0.68*	0.11	0.17	-0.24
40 conf.	M hses 47	-0.31	-0.23	0.44	0.29	0.22	0.40
41	M hses 53	0.69*	0.11	-0.18	-0.15	0.04	0.17
42	F lses 52	0.37	0.01	0.27	-0.15	0.53*	-0.07
43	M lses 55	0.67*	-0.19	-0.01	-0.07	-0.03	0.01
44	F hses 60	0.57*	-0.13	0.02	-0.39	0.31	0.03
45 conf.	F hses 50	0.64	0.43	0.10	-0.28	0.03	-0.10
46	F lses 31	0.54*	-0.03	0.12	-0.36	0.31	0.00
47	F lses 54	0.75*	0.03	-0.27	0.06	0.03	0.04
48	F hses 21	-0.27	-0.19	0.28	0.59*	0.07	-0.03
49	M lses 46	0.39	0.45*	0.14	-0.24	0.01	-0.05

Qsort number	Participant†	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6
50 conf.	F lses 46	0.56	0.01	0.44	-0.45	0.10	-0.03
51	M hses 34	0.56*	0.37	0.06	0.15	0.13	-0.14
52	F lses 39	0.72*	0.04	0.10	-0.31	0.01	-0.04
53	F lses 47	0.77*	-0.17	-0.07	0.07	0.03	0.00
54	F lses 39	0.67*	0.02	0.00	-0.15	-0.07	-0.00
55 n.s.	F lses 35	0.12	-0.18	0.02	-0.30	0.07	-0.15
56	M hses 43	0.19	0.24	-0.12	-0.42*	-0.02	0.02
57	F hses 32	-0.04	0.10	0.43*	0.08	0.00	-0.05
58 conf.	F lses 36	0.25	-0.07	0.54	0.19	0.43	0.08
59	M hses 55	0.73*	-0.12	0.14	0.02	-0.06	0.01
60	F hses 28	0.76*	0.14	-0.29	0.06	0.03	-0.04
61 n.s.	M lses 26	0.30	0.33	0.15	0.32	0.07	-0.17
62	F hses 26	-0.31	0.71*	-0.13	-0.09	0.06	-0.04
63	F lses 27	0.07	0.72*	0.38	0.15	0.08	0.01
64	F hses 31	0.71*	-0.20	-0.07	-0.04	0.22	0.16
Eigens.		14.00	7.7	4.9	3.5	4.2	2.1
Var.		20	11	7	5	6	3

* denotes a loading significant at 0.40 (all except confounded sorts)

† Characteristics of participant, abbreviated to F/M (Female/Male), hses or lses (higher socio-economic status/lower socio-economic status) and age in years. Thus F hses 33 denotes a 33 year old female with higher socio-economic status.

n.s.= non-significant sort

conf.=confounded sort

Table 9.1 Varimax rotated six-factor solution for Q-sort

To aid interpretation, the factor exemplars from a given factor are merged together to produce a single 'ideal' Q sort called a 'factor array'. This is created through a weighted average method, so that exemplars that load at a higher level (e.g. at 0.75) carry more weight than those who load at a lower level (e.g. at 0.45) (Brown 1980). The interpretation of the factors is based principally on their ranking of key items in the (ideal) factor arrays. These are presented in a list format (item plus ranking) for the basis of comparison in Table 9.2 below.

Item	Factor	1	2	3	4	5	6
1. Smoking is my only luxury		0	-4	3	0	-2	-6
2. I sometimes think people forget that a lot of the great artists and musicians smoked		-1	-1	-2	3	-2	-2
3. Smoking is really just a habit for me, something I do.		0	5	2	1	1	2
4. I feel powerless in the face of nicotine addiction.		5	-5	-1	-3	-1	-3
5. When you get stressed, the first thing you do is reach for a cigarette		3	0	3	3	2	-2
6. It is wrong to say that smokers can't be healthy; it all depends on the individual.		-1	1	4	-2	-1	1
7. As long as people are adults, they should be left alone to decide if they want to smoke.		1	4	6	6	6	3
8. I sometimes think smoking looks quite sexy.		-3	-1	-6	5	4	1
9. Smoking is one way of letting your hair down every now and again.		-2	1	-4	-3	3	1
10. I do tend to associate smoking with poorer or less well-educated people.		0	-3	-4	-1	-6	-3
11. Even though I am a smoker, I really don't like smoking		4	2	-5	-5	-1	2
12. Being a smoker these days isolates you from your friends and colleagues.		0	-1	-2	-1	-4	0
13. There are many things I do to enjoy myself, and smoking is one of them.		0	2	5	5	6	-1
14. I am more creative when I smoke		-1	-1	-1	1	-4	-4
15. I don't think too much about why I smoke.		-3	2	5	0	-1	0
16. You may be addicted, but you should still try and do something about it		3	3	-1	-1	1	0
17. Smoking limits the type of life I would like to lead.		3	-2	-5	1	-1	0
18. If I'm honest, there's a bit of me that still feels slightly rebellious when I smoke.		-1	-1	0	3	0	0
19. Smoking is a means of relaxation for me.		2	0	0	3	1	-4
20. Smoking is just another habit like eating too much chocolate		0	-1	6	0	-1	-1
21. It would be a struggle to quit, but I honestly feel that I could stop if I wanted to.		-3	5	0	2	1	1
22. I'm a real worrier, which is one reason I smoke.		2	-3	2	-4	1	-3
23. I think my smoking is very much down to people around me smoking.		-1	3	0	-3	0	-2
24. Health is my number one concern in relation to my smoking.		5	6	0	-1	0	6
25. If I feel my smoking getting out of hand, I tend to do something about it.		-1	6	-1	-5	4	5
26. A little bit of me likes doing something a lot of people disapprove of, like smoking		-1	-2	-6	0	2	3
27. I think smokers in general tend to be a bit more individual than the next person.		-3	-2	-2	2	-3	-1
28. Smoking is the only thing that I've got for myself.		-1	-5	-1	-2	-6	-6
29. People sometimes do think less of smokers, although they shouldn't.		1	2	2	-2	4	2

Item	Factor	1	2	3	4	5	6
30. Smokers are demonized these days, which is quite unfair.		1	-2	1	2	0	1
31. I often feel disgusted at myself for continuing to smoke.		5	1	-4	-6	5	-1
32. Smoking is a chance to escape for a while		1	0	3	0	1	0
33. Smoking should be seen as a medical addiction, just like drug or alcohol addiction.		6	1	2	-1	3	-5
34. I control my smoking, my smoking doesn't control me		-6	4	1	-2	0	-4
35. Smoking helps me cope with life.		1	-3	2	1	0	4
36. I know what the doctors say, but I sometimes feel that the risks of smoking have been exaggerated.		-6	-4	3	-1	2	-4
37. People worry too much about smoking; you could get run over by a bus tomorrow.		-4	1	1	1	1	-1
38. It sounds crazy to say it, but somehow the danger of smoking makes it seem a little bit exciting on some level.		-4	-2	-3	1	-1	2
39. Being seen as a smoker really doesn't bother me.		-1	1	4	6	-3	-2
40. You are not a part of things if you don't smoke.		-4	-4	-3	-2	-3	1
41. I like the fact that being a smoker puts you in a little club with other smokers.		-2	-1	-1	1	-2	3
42. Smoking is a dirty habit, whichever way you look at it.		4	4	-1	-5	2	2
43. One of the only times I get on my own is when I smoke		-2	-4	1	2	-5	4
44. I think smoking is connected with having an addictive personality.		2	3	-5	-2	3	0
45. I'd have no problems stopping; I've done it quite a few times.		-5	0	-3	-4	-4	-2
46. The lack of control is the worst thing about smoking		6	1	-2	-4	-3	4
47. When you think about it, there are lots of things worse than smoking for your health.		-3	-3	1	-2	-3	2
48. The rights of smokers are increasingly ignored.		0	0	-1	4	3	3
49. When I look around, smokers do seem to be more sociable than other people.		-2	0	0	2	-5	0
50. I think smoking looks down-market, even though I do it myself.		2	2	0	-3	0	-3
51. Stopping smoking would be like losing a best friend.		1	-6	-2	2	-1	5
52. Most people are essentially tolerant of smoking, as long as it is not in their face.		0	3	2	0	2	-2
53. I think the dependence aspect of smoking is exaggerated.		-5	-1	4	-1	1	-5
54. I feel like I will never quit smoking.		3	-6	1	4	-2	1
55. Neurotic people are far more likely to smoke		0	-1	-4	-1	-2	-1
56. I give a lot of thought to what cigarettes are doing to my health.		4	3	1	-1	0	6
57. I smoke because life is short, and I want to live for today.		-4	0	1	4	0	-3
58. In general, I think smokers know how to enjoy themselves a bit more than other people.		-2	-2	-1	3	-2	0

Item	Factor	1	2	3	4	5	6
59. I feel that to stop smoking would be to lose part of myself.		1	-3	-3	1	0	1
60. I don't really think my smoking affects the way I live my life.		-5	4	0	0	1	-1
61. People have a really negative perception of smokers nowadays.		1	2	3	0	5	3
62. One of the reasons I smoke is because cigarettes are a stimulant, they get you going when you need it.		1	0	0	0	5	0
63. I can't go without cigarettes for very long, I just can't do without them.		4	-5	0	2	2	-3
64. Smoking often has its roots in emotional problems		2	-2	-3	-3	-4	2
65. I'm aware when I'm smoking that it is a little taste of your own mortality.		0	1	-2	0	3	-2
66. No one group in society smokes, all types of people are smokers.		2	5	5	4	-1	5
67. When I'm bored, the first thing I do is reach for a cigarette.		3	0	4	5	4	-1
68. I'm definitely more laid-back than most non-smokers that I know		-2	1	2	1	-5	1
69. I agree with all these restrictions on smokers, after all, we are the ones in the wrong.		2	0	-2	-6	2	-5
70. I wouldn't really call myself a smoker, more someone who smokes.		-2	2	1	-4	-2	4

Table 9.2 Numerically ordered list of Q-sort items and their rankings across the six factors

The interpretation of each of the six factors below follows the same format. Firstly, the factor is given a title, in this instance relating to smoking identities, which encapsulates the position. The ideal factor array or 'sort' for this factor is then shown, along with the key items (statements) and their relevant ranking in brackets (how strongly they are disagreed or agreed with in this factor, from +6, strongly agree to -6, strongly disagree). Key items are usually chosen from the factor arrays on two bases: the item is ranked at the extremes, indicating a strong agreement or disagreement with the item, or alternately, the item is ranked differently in this factor than in the others, irrespective of the numerical position. All items that are placed at least three ranks apart from their position on other factors are considered distinguishing items and these are highlighted with * (Collins et al. 2002). In addition, verbatim comments from participants are included from the relevant 'exemplars' for each factor to aid the interpretive process.

9.2.2 FACTOR ONE: The 'addicted, unhealthy, out of control' smoker

Twenty-four smokers loaded significantly onto this factor: five females of higher SES (aged 21, 28, 31, 44, 60); nine females of lower SES (aged 21, 21, 31, 31, 34, 39, 39, 47, 54); six males of higher SES (aged 22, 24, 28, 34, 55) and four males of lower SES (aged 24, 24, 55, 60). The ideal factor array for Factor One is presented below.

MOST DISAGREE						→	MOST AGREE					
-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
34	45	37*	8	9	2	1	7	19	5	11	4*	33*
36*	53	38	15	41	6	3	29	22	16	42	24	46
60*	49	21*	43	14	10	30	44	17	56	31		
	57	27	49	18	12	32	50	54	63			
	47	58	23	13	51	64	67					
		68	25	20	59	66						
		70	26	48	61	69						
			28	52	62							
			35	53	39							
					65							

(Disagree) (Agree)

*Indicates distinguishing items

Table 9.3 Ideal factor array for Factor (1)

It is clear that for these smokers, health is the dominant aspect of smoking. This is shown in the way they agree strongly with the following items:

24. Health is my number one concern in relation to smoking (+5)

56. I give a lot of thought of what cigarettes are doing to my health (+4)

They also disagree strongly with the following item:

36. I know what the doctors say, but I sometimes feel that the risks of smoking have been exaggerated (-6)

As Participant 51 (male, higher SES, aged 34) puts it, *'If cigarettes had no harmful side effects, where would the problem be? Health is certainly the key issue for me'*.

Moreover, they wholeheartedly endorse a medicalized 'dependence' model of smoking. Smoking is conceptualised distinctively as a severe medical addiction:

33. Smoking should be seen as a medical addiction, just like drug or alcohol addiction(+6)*

53. I think the dependence aspect of smoking is exaggerated (-5)

The link between smoking and other drug addictions is embraced: *'It is more addictive than heroin* (Participant 60, female, higher SES, aged 28)'; *'Smokers are preoccupied with where their next nicotine fix is, the nicotine monkey on their backs'* (Participant 52, female, lower SES, aged 29). There are several consequent implications of conceptualising smoking this way. Some see it as a rationale for further stigmatisation, for example, Participant 53 (female, lower SES aged 47) says in response to Item 33, *'People's perception of smoking is much like the view taken of people who are overweight: it is their own fault'* The majority, however, feel that it is an entitlement to treatment, *'It is SO hard to give up precisely because it is an addiction. The NHS should spend far more money treating it as such'* (Participant 51, male higher SES, aged 34).

Inherent in these smokers' conceptualisation of their 'addiction' is an attendant lack of self-control:

4. I feel powerless in the face of nicotine addiction (+5)*

21. It would be a struggle to quit, but I honestly feel that I could stop if I wanted to (-3)*

46. The lack of control is the worst thing about smoking (+6)

34. I control my smoking, my smoking doesn't control me (-6)

Participant 52 (female, lower SES, aged 29) offers this example, *'Even in my sleep I've awoke to find myself smoking with an imaginary cigarette.'* This feeling of powerlessness is connected with several emotions, primarily self-resentment. It also leads to guilt for this group of smokers as they do things they perceive as wrong, such as smoke around children: *'Nicotine seems to have power over me, I am unable to stop, despite lack of time, finances and consideration for others even though these factors are usually important to me'* (Participant 44, female, higher SES, aged 60).

Consequently, smokers loading significantly onto this factor have a very negative self-identity around smoking:

11. Even though I am a smoker, I don't really like smoking (+4)

31. I often feel disgusted at myself for continuing to smoke (+5)

42. Smoking is a dirty habit, whichever way you look at it (+4)

Several participants evidence this self-dislike: *'I never feel good about myself for smoking'* (Participant 46, female, lower SES, 31); *'I really hate myself, the smell on my skin, hair'* (Participant 52, female lower SES, aged 39). There is also an adoption of the (perceived) negative judgement of others, *'Smokers feel very dirty in the presence of non-smokers when all it is they are doing is smoking a cigarette'* (Participant 59, male higher SES, aged 55).

Being a smoker in this factor is therefore seen as limiting rather than liberating. The ranking of these items also indicates the core centrality of being a smoker for these individuals:

17. Smoking limits the type of life I would like to lead (+3)

60. I don't think my smoking affects the way that I live (-5) *

There is also a clear rejection of cavalier or fatalistic attitudes to risk. This group of smokers value future health over any present benefits of smoking, whether excitement, living for the moment or social inclusion:

37. People worry too much, you could get run over by a bus tomorrow (-4)*

38. It sounds crazy to say it, but somehow the danger of smoking makes it seem a little bit exciting on some level (-4)

40. You are not a part of things if you don't smoke (-4)

57. I smoke because life is short, and I want to live for today (-4)

In response to Item 38, Participant 15 (male, higher SES, aged 24) comments, *'This is the reason for smoking that annoys me the most. I would think a tiny proportion of 'smokers' actually think this; they just think it sounds cool and end up making all 'smokers' look pathetic. They should just admit addiction'*.

Item 7 is also uniquely ranked neutrally in this factor:

7. As long as people are adults, they should be left alone to decide if they want to smoke. (+1)

Participant 2 (male, higher SES, aged 22) responds to this item, *'Adults are still humans and need all the encouragement that they can get. Each person is worth saving, no matter how old'*.

Looking at the demographic characteristics of smokers loading significantly onto this factor, eleven were higher SES and thirteen were lower SES. This tends to suggest that the representation of smokers evidenced in this factor is not only socially dominant

(being the largest factor) but pervasive, being shared by participants across different social position. Participants of all ages also load onto this factor.

In summary, therefore, smokers who load significantly onto this factor share a strong identity around smoking. Smoking is central in their lives due to its (negative) impact on day to day living. Their representation of the smoker fits with the dominant medical model; smokers are understood to be medically addicted, unhealthy individuals. Health is their primary value and other values such as excitement, risk or living for today are directly rejected. Control (or the lack of it) is a key feature in this identity, particularly feelings of powerlessness. Consequently, these smokers feel they should be the (needy or entitled) recipients of medical attention and intervention. Finally, smokers loading on this factor reveal very strong feelings of self-dislike and disgust for their status as smokers; this is not an identity which they wish to hold.

9.2.3 *FACTOR TWO: The 'not really a smoker' smoker*

Sixteen smokers loaded significantly onto this factor: ten females with higher SES (aged 20, 20, 21, 21, 25, 26, 27, 27, 28, 33); three females with lower SES (aged 21, 21, 27); two males with higher SES (aged 28 and 31) and one male with lower SES (aged 46). The ideal factor array for Factor Two is presented below.

MOST DISAGREE						→		MOST AGREE					
-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6	
51*	4*	1	10	17	2	5	6	11	16	7	3*	24	
54*	28	36	22	26	8	19	9	13	23*	34*	21*	25	
		63	40	35	27	12	32	31	15	44	42	66	
			43	47	30	14	45	33	29	52	60*		
				59	38	18	48	37	50	56			
					58	20	49	39	61				
						64	41	57	46	70			
							53	62	65				
								55	67	68			
										69			
(Disagree)													(Agree)

*Indicates distinguishing items

Table 9.4 Ideal factor array for Factor (2)

There is no attempt to dismiss many aspects of the dominant understanding of smoking in this factor. This is indicated by a similar ranking on **Items 24 (+6), 36 (-4) and 42 (+4)** to Factor One. These smokers are concerned about their health and view smoking as a dirty habit: *'As much as I enjoy smoking, I am very concerned about my health and have therefore cut down greatly'* (Participant 63, female, lower SES, aged 27.)

However, their personal relationship with this dominant model is quite different: they distance themselves from it completely. They do not characterize their own personal smoking in terms of a medical addiction, though there is no attempt to deny others may be addicted. Rather smoking is distinctively understood as a 'habit' and a social activity, sustained by the presence of others smoking in a social environment:

3. Smoking is really just a habit for me, something I do (+5)*

23. I think my smoking is very much down to people around me (+3) *

Thus Participant 21 (female, higher SES, aged 21) comments *'I don't think I am actually addicted. It is more by force of habit that I smoke (I hope)!' It is unclear whether such social smoking constitutes 'peer pressure' as such. What is undeniable is that smoking in a social context is experienced as pleasurable: 'I only seem to smoke when I'm out with my smoker friends-it's not peer pressure, but rather a reminder that smoking feels good and if others let themselves do it, then why can't I?' (Participant 23, female, lower SES, aged 20); 'I hate the fact I'm so susceptible to peer pressure, though I adore to indulge that feeling of being 'naughty' with other people' (Participant 10, female, higher SES, aged 28).*

Thus smoking is more down to others, not an essential need for the self. Nor is it core to their self-identity or pleasure:

1. Smoking is my only luxury (-4)

28. Smoking is the only thing that I've got for myself (-5)

43. One of the only times I get on my own is when I smoke (-4)

The comments accompanying these items indicate a desire to distance oneself from the image of a needy, solo smoker: *'It sounds ridiculous to say 'smoking is the only thing I've got'! I don't think things could ever get that bad!' (Participant 24, female, lower SES, aged 21.) Although smoking is a pleasure, it is not a solitary one (in both senses of the term solitary). Participant 1 (female, higher SES, aged 34) clarifies this 'I don't particularly think of it as a luxury, also I have other luxuries when luxury is required!'*

Unique to this factor is a strong emphasis on personal self-agency and control over one's smoking, in marked contrast to Factor One:

34. I control my smoking, my smoking doesn't control me (+4)*

21. It would be a struggle to quit, but I honestly feel that I could stop if I wanted to

(+5)*

25. If I feel my smoking getting out of hand, I tend to do something about it (+6)

54. I feel like I will never quit smoking (-6) *

4. I feel powerless in the face of nicotine addiction (-5)*

63. I can't go without cigarettes for very long (-5)

Participants do not dispute the addictive nature or loss of control for some smokers, but make it clear that this does not personally apply to them. Thus Participant 62 (female, higher SES, aged 26) says *'I don't crave or depend on smoking. I naturally have long periods in between without it even coming to my mind'*. The concept of personal self-control is also linked with personal freedom: *'I've stopped smoking a couple of times and started again from my own free will.'* (Participant 17, male, higher SES, aged 28).

Again, in marked contrast to Factor One, being a smoker is not felt to be a central feature of these individuals' lives:

60. I don't really think my smoking affects the way I live my life (+4)*

51. Stopping smoking would be like losing a best friend (-6)*

4. As long as people are adults, they should be left alone to decide if they want to smoke (+4)

As Participant 62 (female, higher SES, aged 26) comments, *'I don't need it to live my life...I live my life the same as when I wasn't smoking, nothing is different'*.

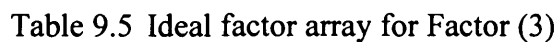
Unlike Factor One, the characteristics of participants loading onto Factor 2 are more distinct (not in the statistical sense). They are predominantly higher SES (12 participants) as opposed to lower SES (4 participants). They are also younger (15 aged 20-40) rather than older (1 aged over 40). This appears to be, therefore, an identity which is held by young, more affluent individuals who have considerable psychological

motivation to distance themselves from being seen as addicted, out-of-control, unhealthy smokers.

In summary, participants loading onto this factor are well aware of the dominant understanding of smoking and do not dispute it at any real level. However, their identity as smokers is clearly distanced from this; they see themselves as ‘social’ not ‘addicted’ smokers. Smoking is habitual, an adult choice, not a dominant feature in life and something over which they can exercise self-control. There is a clear rejection of the idea that smoking is an essential aspect of life or self-identity. Any negative fall-out from being seen as a ‘typical’ smoker (as exemplified by Factor One) is therefore avoided through this understanding.

9.2.4 *FACTOR THREE: The ‘laissez-faire’ smoker (bipolar)*

Five smokers loaded onto this factor, four positively and one negatively, making this a bi-polar factor. The positive loadings came from two females of higher SES (aged 28 and 32), a female of lower SES (aged 23) and a male of higher SES (aged 25). The negative loading was from a female of higher SES aged 27. The ideal factor array for Factor Three is shown below.



Another ‘stereotype’ that is uniquely challenged by this group is that smokers are unhealthy:

6. It is wrong to say smokers can’t be healthy, it all depends on the individual (+4)

*

Several participants expressed their belief that it is perfectly possible to be a fit smoker: *‘Based on myself, I am very healthy and fit, even though I have been smoking for nearly 10 years; fitter than friends who have never smoked’* (Participant 26, male, higher SES, aged 25).

Furthermore, the ‘severe addiction’ model of smoking of Factor One is refuted:

44. I think smoking is connected with an addictive personality (-5) *

53. I think the dependence aspect of smoking is exaggerated (+4) *

20. Smoking is just another habit like eating too much chocolate (+6) *

Unlike Factor One smokers, participants loading onto this factor dismiss the notion that smoking has any equivalence with other severe drug addictions: *‘People always say that smoking is bad for you, but it’s not as bad as drinking excessive alcohol, taking drugs’* (Participant 39, female, lower SES, aged 23.); *‘The risks of abusing alcohol are far worse than cigarettes, smoke doesn’t kill other people directly’* (Participant 14, female, higher SES, aged 22). Smoking is therefore seen as a minimally addictive, similar to chocolate or coffee. As Participant 57 (female, higher SES, aged 32) says *‘A chocoholic would not want to give up and neither would I’*.

Control appears not to be a major dimension of this Factor. Very few of the numerous items concerning self-control and quitting ability are ranked in extreme positions, in contrast to Factor One and Two. It is therefore unclear whether, having dismissed the

seriously addictive nature of smoking, these smokers perceive themselves as controlling or needing their cigarettes.

The smokers who load positively onto this Factor are keen to replace these ‘stereotypes’ of smokers with their own understanding. As with Factor Two, smoking is characterised positively in terms of what it can offer. It is understood to be enjoyable and a way of combating boredom. However, uniquely, these smokers do not over-analyse their motivation to smoke:

13. There are many things I do to enjoy myself, and smoking is one of them (+5)

67. When I’m bored, the first thing I do is reach for a cigarette (+4)

15. I don’t think too much about why I smoke (+5)*

In terms of identity as a smoker, these smokers are relatively relaxed. There see no need to distance themselves from being smokers, as in Factor Two. Nor is being a smoker a matter of disgust, self-hatred or limitation, as in Factor One:

39. Being seen as a smoker really doesn’t bother me (+4)

31. I often feel disgusted at myself for continuing to smoke (-4)

11. Even though I am a smoker, I really don’t like smoking (-5)

17. Smoking limits the kind of life I would like to lead (-5)*

Participant 57 (female, higher SES, aged 32) evidences this willingness to embrace smoking as part of self-identity: *‘Smoking is part of me, part of who I am. I smoke because I enjoy it’*. On the other hand, Participant 26 (male, higher SES, aged 25) is more cautious about the reactions this identity might provoke: *‘I know that everyone judges everyone on first appearance and in certain situations I don’t like to be perceived as a smoker.’*

Only one participant loaded negatively onto this factor (Participant 6, female, higher SES, aged 27). It is difficult to offer a complete interpretation as this individual made very few comments. She has considerable health fears '*I don't want to die of lung cancer*', feels life is limited, '*I always have to carry cigarettes with me and it's so expensive*' and is disgusted with herself for continuing to smoke. She therefore has a very similar smoking identity to those loading positively onto Factor One. Given that Factor Three represents in many ways an 'oppositional' position to Factor One, it is perhaps not surprising that one person has loaded negatively onto it.

In summary, the smoking identity evidenced in Factor Three has as its starting point a rejection of stereotypes about smokers (as unhealthy, severely addicted, neurotic, rebellious or sexy). As such, it is a position of opposition to perceived threat and judgement. These smokers prefer to characterise themselves quite differently, as having a laissez-faire, relaxed attitude to both their smoking behaviour and their status as smokers. They do not see the purpose in over-analysing their smoking behaviour, although what it has to offer is primarily positive. They are also accepting of the fact that they smoke, and therefore, by and large, are accepting of their identity as smokers. Other positive identities, such as being healthy, are not, in this conceptualisation, mutually exclusive with being a smoker.

9.2.5 FACTOR FOUR: The 'proud' smoker (bipolar)

The Q-sorts of three smokers loaded significantly onto this factor, two positively and one negatively. The Q-sort of the two smokers who loaded significantly in a positive direction were a higher SES female aged 21 and a higher SES male aged 27. The negatively loaded Q-sort was completed by a 43 year old male with higher SES. The ideal factor array for Factor Four is shown below.

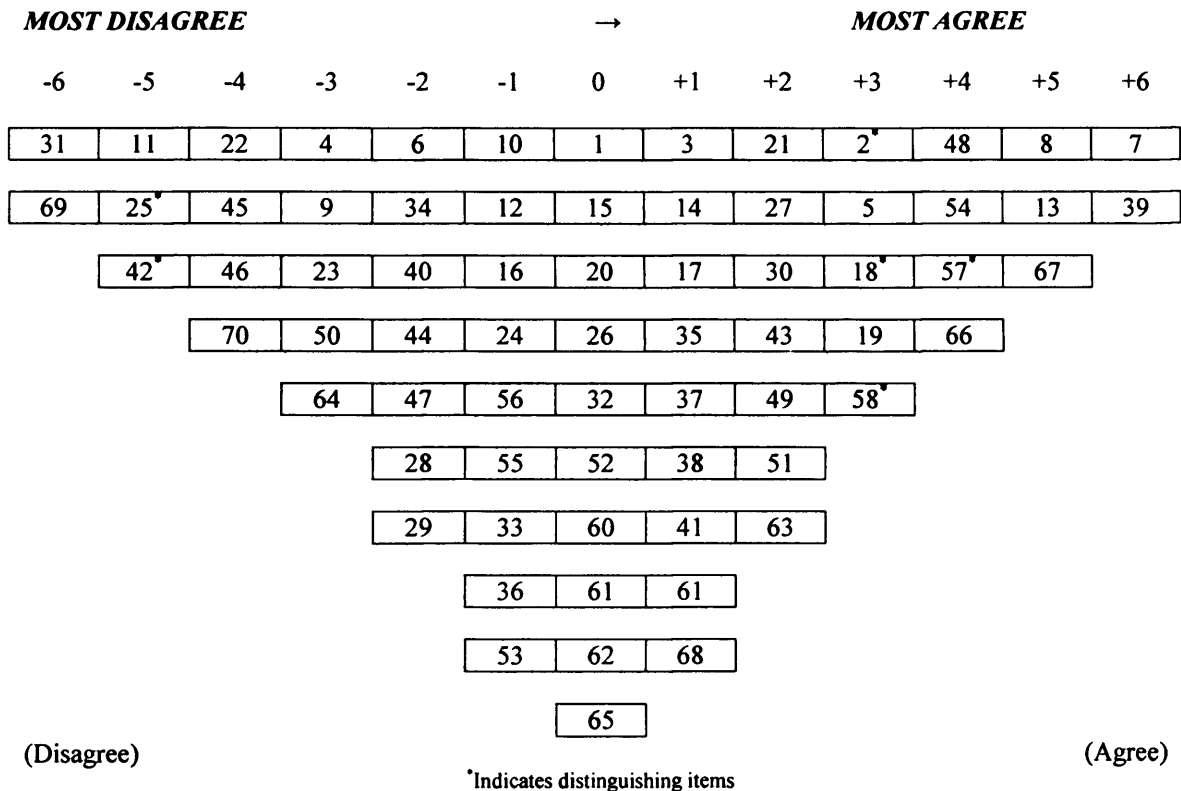


Table 9.6 Ideal factor array for Factor (4)

In Factor Four, the function of smoking is understood similarly to Factor Three. It is both enjoyable (**Item 13, +5**) and a way of counteracting boredom (**Item 67, +5**).

However, unlike Factor Three where participants rejected many of the positive connotations of smokers, the smokers here positively embrace them. The Items 2, 18 and 58 (shown below) are not ranked positively at all in any other factor. Smokers are seen here in a unique way, as sexy, artistic, and rebellious, the type of people who know how to enjoy themselves:

8. I sometimes think smoking looks quite sexy (+5)

2. I sometimes think people forget that a lot of the great artists and musicians smoked (+3) *

18. If I'm honest, there's a bit of me that still feels slightly rebellious when I smoke
(+3) *

58. In general, smokers know how to enjoy themselves a bit more than other people (+3) *

Participant 4 (male, higher SES, aged 27) gives this example: *'I think a woman who is smoking but has an element of grace is really sexy. Must be my oral fixation, cheers Sigmund.'* Non-smokers on the other hand, are seen as boring, and there is a clear preference for the in-group (smokers): *'Strange enough, maybe I'm being prejudiced, but when someone I meet says he/she doesn't smoke, I immediately catch myself thinking 'he/she must be boring' (Participant 48, female, higher SES, aged 21). She goes on to add: 'I would never consider a non-smoker as a potential boyfriend... (Still I never say I wish I didn't smoke, I say I wish he were a smoker) (!)'*

Another distinct value that these smokers hold, in addition to living life to the full, is living for the moment:

57. I smoke because life is short and I want to live for today (+4)*

As in several of the factors (3, 4, and 5), smoking is seen as a matter of personal choice for adults. However, participants loading onto this factor are also concerned with what they see as the encroachment of smokers' rights:

7. As long as people are adults, they should be left alone to decide if they want to smoke (+6)

48. The rights of smokers are increasingly ignored (+4)

69. I agree with all the restrictions on smokers (-6)

Freedom and a liberal (relative) interpretation of morality are prioritised: *'Outside of the obvious things (murder, rape etc), I have a bit of a problem with the right/wrong concept. Nothing is set in stone, it's just popular opinion' (Participant 4)*

Given their positive connotations of being a smoker, it is perhaps not surprising that these participants are more than happy to identify themselves as smokers. Being a smoker is neither disgusting nor dirty, but something to be embraced:

39. Being seen as a smoker really doesn't bother me (+6)

70. I wouldn't really call myself a smoker, more someone who smokes (-4)

11. Even though I am a smoker, I really don't like smoking (-5)

31. I often feel disgusted at myself for continuing to smoke (-6)

42. Smoking is a dirty habit, whichever way you look at it (-5)*

In relation to Item 11, Participant 48 exclaims '*I LOVE SMOKING! I HATE HYPOCRISY! I find it funny that some people keep on saying they don't like smoking and keep on trying to quit (in vain), because if you don't like smoking, you don't do it*'.

They don't harbour any illusions about being able to quit easily, but the lack of control is not a matter for regret. Stopping is just not a priority:

54. I feel like I will never quit smoking (+4)

25. If I feel my smoking getting out of hand, I do something about it (-5)*

46. The lack of control is the worst thing about smoking (-4)

As with Factor Three, just one participant loaded negatively onto this factor (Participant 56, male, higher SES, aged 43). In addition to accepting the dominant position of smoking as an out-of-control addiction (as with Factor One), this smoker distinctively goes further in disavowing smokers' rights. For example, he disagrees strongly with **Item 7** '*because people's health would decline without health warnings*'. He also strongly agrees that smokers should be restricted as they are the ones in the wrong (**Item 69**) '*because it is unfair for non-smokers to damage their health due to our*

addiction'. The key to this negative loading is therefore the belief that smokers have forfeited their rights along with the adoption of their addiction.

All three participants who loaded significantly onto this factor were higher SES. This might suggest that higher SES individuals were orientated around this identity one way or another, whether strongly identifying with it, or conversely rejecting it entirely.

In summary, Factor Four represents a strong smoking identity. The smokers who load positively onto it are 'proud' to be smokers, who they characterise as 'bon viveurs'. Smoking has positive connotations of sexiness, rebelliousness and an artistic temperament. The values they draw on are freedom, living for today and living life to the full. Smokers' rights to live this way are, in their opinion, currently being eroded. Participant 4 sums up this 'in your face' identity by including the following comment : *'If anyone has a problem with this (smoking), might I suggest you taking a look around at the world in which we live and...shutting your fucking mouth' Bill Hicks, Relentless, 1991*'.

9.2.6 FACTOR FIVE: The 'anti-social, social' smoker

Four smokers loaded significantly onto this factor: a higher SES female aged 50, two lower SES females aged 51 and 52 and a higher SES male aged 25. The ideal factor array for Factor Five is presented below:

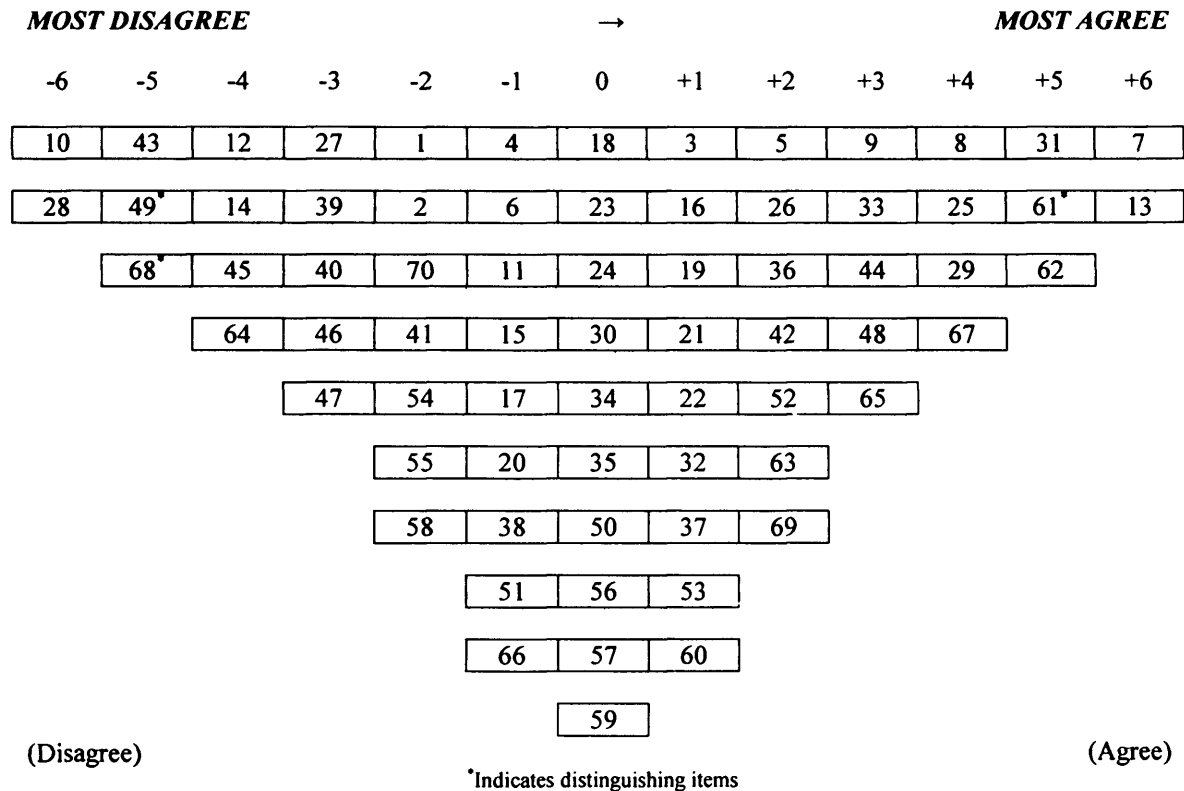


Table 9.7 Ideal factor array for Factor (5)

The functions of smoking in Factor Five are conceptualised similarly in Factor Four. Smoking is seen as enjoyable (**Item 13, +6**), sexy (**Item 8, +4**) and a response to boredom (**Item 67, +4**). It is also uniquely characterised as a stimulant:

62. Cigarettes are a stimulant, they get you going (+5) *

Consequently, participants do not feel they are particularly laid-back:

68. I'm definitely more laid-back than most non-smokers that I know (-5)*

Like Factor Two, for these smokers, smoking usually takes place in a social rather than solitary environment and does not lead to social isolation:

28. Smoking is the only thing that I've got for myself (-6)

43. One of the only times I get on my own is when I smoke (-5)

12. Being a smoker these days isolates you from your friends and colleagues (-4)

Participant 8 (male, higher SES, aged 25) thus responds to Item 12 *'Quite the contrary, most people smoke'*.

However, although these smokers view their own habit relatively positively as enjoyable and stimulating, they certainly do not think that others share their opinion. Participants loading significantly onto this factor are concerned with the social stigma of being seen as a smoker:

29. People sometimes do think less of smokers, although they shouldn't (+4)

61. People have a really negative perception of smokers nowadays (+5)

49. When I look around, smokers do seem to be more sociable than other people (-5)*

As Participant 3 (female, higher SES, aged 50) explains *'I have got the feeling in the past that smokers are bad people'*.

To some extent, this social disapproval appears to have been internalised as feelings of disgust, as shown by the ranking of this item (ranked similarly only by Factor One):

31. I often feel disgusted at myself for continuing to smoke (+5)

In terms of the characteristics of the participants who loaded significantly onto this factor, they appear evenly distributed in terms of SES (two lower and higher), but not age, with three participants over 50 years old. As the key experience of these participants appears to be stigmatisation, this is likely to be linked to the social change in the social identities of smokers over the past thirty or forty years, from socially acceptable to 'pariah', at least in the perceptions of these individuals.

In summary, the motivation for smoking for Factor Five participants is clear: cigarettes are experienced as enjoyable and a stimulant. Smoking is not about satisfying internal

needs, but socialising. However, the price paid for these benefits, in terms of overall societal image (and thus identity) is high. Smokers are seen generally in society as 'anti-social', thus generating the paradox of the 'anti-social social' smoker. This may be linked to the older age of these smokers and their experience of the social changes surrounding smokers' identities. This stigmatisation is accepted and internalised, the smoker is disgusted with themselves for continuing to smoke.

9.2.7 FACTOR SIX: The 'ambivalent' smoker

Only two participants loaded significantly onto this factor: both males, one higher SES aged 22 and one lower SES aged 34 years.

MOST DISAGREE						→	MOST AGREE					
-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
1	33*	14	4	2	13	12	6	3	7	35	25	24
28	69	19	10	5	20	15	8	11	26	43	51*	56
53 36 22 23 27 16 9 29 41 46 66												
34 57 39 31 17 21 38 48 70												
63 45 37 18 30 42 61												
50 52 32 40 47												
65 55 44 54 64												
60 49 59												
67 58 68												
62												
(Disagree)							(Agree)					

*Indicates distinguishing items

Table 9.8 Ideal factor array for Factor (6)

The ideal factor array for Factor Six is presented above. Smoking is uniquely conceptualised in this factor as a coping mechanism for dealing with everyday life.

35. Smoking helps me cope with life (+4)**43. One of the only times I get on my own is when I smoke (+4)**

For Participant 31 (male, lower SES, aged 34) it is an opportunity for time out: *'It becomes an excuse to have five minutes away from the kids'*.

Additionally, this factor is distinguished by several sets of seemingly contradictory statements which are scored highly.

On the one hand, there is some similarity with Factor One, in that there is considerable concern over the health consequences of smoking (**Item 24, +6; Item 56, +4; Item 36, -6; Item 53, -5**). Thus Participant 19 (male, higher SES, aged 24) says *'I can feel what smoking is doing and want to overcome the problem.'* On the other hand, alongside this acceptance of the medical model, there is a strong resistance to go all the way and acknowledge it as a severe addiction:

33. Smoking should be seen as a medical addiction, just like drug or alcohol addiction (-6)*

A similar duality exists concerning these participants' perceived control over their smoking behaviour. On the one hand the lack of control causes considerable concern:

34. I control my smoking, my smoking doesn't control me (-6)**46. The lack of control is the worst thing about smoking (+4)**

On the other, they still try to show their ability to manage the situation:

25. If I feel my smoking getting out of hand, I tend to do something about it (+5)

Similarly participants appear to have contradictory aspects concerning their self-identity as smokers. On the one hand, they are the only participants to acknowledge the great loss that quitting smoking would cause:

51. Stopping smoking would be like losing a best friend (+5)*

These participants simply cannot envisage their lives (or themselves) without smoking: *'I don't remember what I was like before smoking'* (Participant 19); *'It would be hard to imagine life without smoking routines'* (Participant 31)

On the other hand, they are even reluctant to label themselves as smokers:

70. I wouldn't really call myself a smoker, more someone who smokes (+4)

Participant 31 states *'even after 20 years as a smoker, I don't consider myself a real smoker.'*

In summary, the two participants who loaded significantly onto this factor are essentially ambivalent about many aspects of their smoking. It is unclear from their comments why this is the case. Perhaps one clue might be found in the function of smoking in this factor, as a way to cope. Smoking is thus utterly central in these men's lives, described literally a 'best friend'. However, the dominance of smoking in their lives might also be threatening to their self-identity. They therefore claim they can manage the problem and even reject the label 'smoker'. The number of contradictory statements can therefore be interpreted as identity work on their part. Such tactics may offer some protection for their sense of (threatened) self.

9.3 Results: Class/SES Items

Given the results of the interview study, in which it was found that some participants perceived there to be a relation between lower social status and smoking, it was decided

to include this as a subject of several statements in the Q-sort. Three items were included:

66. No one group in society smokes, all types of people are smokers.

10. I do tend to associate smoking with poorer or less well-educated people.

50. I think smoking looks down-market, even though I do it myself.

The results of the Q-sort in relation to these three items showed two things: that this topic was highly salient for participants and that there was an almost unanimous rejection of any overt class-smoking link.

The salience of this topic is shown by the frequency with which these statements were included in the comments (as each participant could only select a limited number of 7). Nearly 40% (24 out of 64) chose one of these three statements to comment on out of seventy. Examining the valance of those comments, twenty-one participants, a third of the total, were negative, rejecting any link between social position and smoking at all. Only three participants either commented ambiguously on the link or agreed that there was one.

The almost unanimous rejection of this idea is shown by the rankings of the three items. None of these statements were defining for any of the factors, indicating there was considerable consensus amongst participants in their opinions. Statement 10, which is perhaps the most blatant statement of a class-smoking link, was ranked negatively amongst all factors, with only Factor 1 giving a neutral ranking (0). There was also almost universal agreement with Statement 66, that all types of people smoke, except a slight negative ranking for Factor 5 (-1). However, the ranking of Statement 50, where smoking is described as 'down-market' is interesting. Factors 1 and 2, the socially shared dominant identities, have a positive ranking for this item (2), suggesting some,

though not strong agreement, with this notion. On the other hand, Factors 4 and 6 reject the idea out of hand (-3). This suggests that although an overt link between class and smoking is rejected by participants, there is an (unarticulated) awareness by the majority of participants that smoking does not enhance their social position in the eyes of others.

Most of the comments focused on the perceived lack of evidence for a class-smoking link. For example, Participant 5 (male, higher SES, aged) argues: *'Most smokers I know are middle-class, mid-range income earners and well-educated'*. Participant 32 (male, lower SES, aged 24) comments: *'All walks of life smoke, black, white, young, old, male, female, tall, short, fat or thin, it doesn't matter'*, a theme echoed by Participant 25 (female, lower SES, aged 21): *'All sorts of people smoke and I think addiction to nicotine transcends all social barriers.'*

Other comments focused on the equivalence of the risks of smoking across social divides. For example, Participant 24 states: *'It's interesting that regardless of class or education, nobody seems safe from smoking'* (female, lower SES aged 21). However, another participant (22, female, lower SES, aged 20) points out that certain inequalities exist for smokers in the health-care system: *'You cannot equate class with smoking- the middle class smoke, but can pay when they get fucked lungs.'*

Others reacted to what they perceived as the stereotypical and judgemental attitude behind the statements. Participant 28 (male, lower SES, aged 59) found Statement 10 *'Very insulting, even doctors and nurses indulge'*. Similarly Participant 62 (female higher SES, aged 26) reacted as follows: *'It's a judgemental comment, stereotypical view of people. I thought this unfair'*.

Only, three participants, all higher SES, expressed ambivalence or agreed with the idea that smoking could be linked with social position. Participant 10 (female, higher SES,

aged 28) comments *'Although this [Statement 10] is true, I also know plenty of well-educated and affluent people who smoke-even though they have less excuse'*. Only one participant (59, male, higher SES, aged 55) in the whole study commented on the perception of smokers as 'down-market': *'People see smokers as common and non-smokers are prejudiced against them and avoid them and smokers are isolated'*.

In summary, the Q-items on smoking and social position provoked a strong reaction from numerous participants. Overall, the vast majority rejected any direct perceived link between social position and smoking. They were keen to stress the 'inclusive' nature of smoking, cutting across all classes and social boundaries. This in itself may well be a defence against some of the negative aspects of being seen as a smoker. Although these not denied, particularly in Factors 1, 2 and 5, they are mitigated by the idea that lots of other people also share this identity (and therefore can't be that 'bad'). The salience of these items and their accompanying remarks reflect the sensitivity of many smokers towards this issue; it evoked a considerable amount of indignation at its introduction.

9.4 Discussion

The Q-sort results suggest that six distinct, interpretable, smoking 'identities' can be discerned. These constitute the 'addicted, unhealthy, out of control' smoker (Factor One), the 'not really a smoker' smoker (Factor Two), the 'laissez-faire' smoker (Factor Three), the 'proud' smoker (Factor Four), the 'anti-social social' smoker (Factor Five) and finally the 'ambivalent' smoker (Factor Six). There is a clear conceptual divide between the six factors. Factor One, Two and Six all reflect identities oriented around a dominant biomedical model of smoking which has been explored in the interview study. For Factors Three, Four and Five, health is not the primary orienting issue; they reflect the creation of different identities around smoking. The understandings inherent in each

factor and the consequent implications for smoking cessation particularly amongst different socio-economic groups are now considered in detail.

Factor One, the largest factor, represents a wholehearted identification with the dominant, biomedical model of smoking and smokers (e.g. West, R., McNeill, A., and Raw, M. (2000). The clear inter-relationship between health, addiction and stigma, examined separately in the interview study, can be seen here. The core value is 'health', in line with Crawford (1979). Other societal values such as excitement, risk and living for today are directly rejected. The smokers loading significantly onto this Factor are worried about how the health risks of smoking will personally affect them. They also identify themselves as 'out of control' smokers, demonstrated by their uniquely high scoring of the statement, *'I feel powerless in the face of nicotine addiction'*. Finally, they also evidence feelings of dislike and disgust towards themselves for their 'dirty' habit. As discussed in Chapter Six, this notion of 'contamination' is at the heart of the designation of a 'spoiled' social identity (Waldorf & Biernacki, 1981) for the modern smoker. This Factor therefore brings together the primary dimensions of poor health, addiction and a negative aesthetic into one cohesive smoking identity.

As discussed in Chapter Eight, the Western valuation of health above all other values has been extensively critiqued (e.g. Crawford, 1978; Petersen and Lupton, 1996; Skrabanek, 1994). It has been argued that the 'New Public Health Paradigm' leads to the valuation of healthy people above all others and the moral denigration and social exclusion of individuals who fail to meet these ideals through lifestyle choices such as smoking. However, one should not too readily dismiss this biomedical model, particularly in the context of health promotion. This Factor is the largest, with twenty-four out of fifty-four significant sorts loading onto it, with participants from both lower and higher SES groups. That health risk and addiction are indeed the dominant filters

through which smoking is now viewed by lay people is not surprising. The substance of the healthism critiques is precisely the dominance of this medicalized model of lifestyle behaviours. However, to ignore this, and its pervasive influence in lay thinking, is as perilous as ignoring other understandings of smoking and smokers.

It is also interesting to consider when this ‘addicted, out of control’ identity might become embedded in the thinking of adult smokers. Research by Johnson et al., (2003) and Amos et al., (2006) suggest that addicted smoking as exemplified in this first Factor is only one end of the spectrum of dependence as conceptualised by mid-late adolescents. For example, Amos et al. (2006) found that only approximately one-fifth of teenagers aged 16-19 in their study identified themselves as ‘real’, ‘full-fledged’ or ‘proper’ smokers with the corresponding addiction to nicotine as a substance that they thought this implied. In this sample, aged between 20-60 years of age, over two-fifths of the smokers understood themselves to be addicted and their smoking to be ‘out of control’ in this sense. One reason for this difference is undoubtedly the length of smoking career of some of the participants, who may have been smoking twenty to thirty years or more. It would appear to be harder and harder to sustain to oneself and others a ‘social’ or ‘ambivalent’ identity the longer one goes into a smoking career and the more it becomes clear that one’s smoking is embedded in daily life rather than a peripheral, ‘social’ activity. Thus, for these smokers, the ‘need’ to smoke is all too tangible; one participant (52) even talks about smoking an imaginary cigarette in their sleep.

Furthermore, for particular social groups, such as the disadvantaged, this ‘addicted smoker’ identity may be arrived at earlier than for others. Bancroft et al., (2003) have shown that the career trajectories and social contexts in which the adolescent finds themselves (e.g. school, university, work) and the restrictiveness or alternatively social

acceptance of smoking in these contexts can play a big part in encouraging more regular and dependent smoking patterns. It is interesting to note that, although not statistically tested, a large number of lower SES females load onto this factor. This fits with previous research which identifies disadvantaged female smokers as a group particularly vulnerable through their caring responsibilities and psycho-social stress to dependent smoking (e.g. Graham, 1993 a and b; Bancroft et al., 2003).

It is also worth noting that the dominance of the 'addicted, unhealthy, out of control' smoker identity in this Q-sort may, to some extent, reflect the characteristics of the participants in this particular sample. A significant minority of participants (n=17) were home-based and not in full-time employment, many either caring for children or on long-term disability/unemployed. The large number of home-based participants reflects the postal nature of the task which took a reasonable amount of time to complete, plus the use of 'adverts' to find participants. As the Q-sort table of participants shows, this group tend to be heavier smokers with dependent patterns of smoking (e.g. most smoking within 30 minutes of waking).

A key question, in the light of the dominance of this 'addicted, out of control' identity is whether encouraging smokers to think of themselves as at high risk and medically addicted is a facilitative tool for smoking cessation or a barrier to success. An addiction model gives an easily understood account of why smokers often struggle to quit, or why they might crave cigarettes on an hourly basis. A medical model is also a treatment-oriented model, which may promote treatment-seeking behaviour, although evidence shows that most people still self-treat rather than seek external help (West et al., 2002). However, other theorists such as Warburton have argued that concepts such as 'cravings' or 'withdrawal symptoms' may in fact encourage smokers to label and fear these physical experiences in a counter-productive manner (Gilbert & Warburton,

2000). Gillies and Willig (1997) also argue, in the context of investigating gender and smoking, that addiction discourses are disempowering, given the central tenet that one is 'out of control'. A related point was made in Chapter Seven: attributions of addiction are only facilitative if one believes one has the tools to conquer an addiction.

If Factor One represents a wholehearted acceptance of the biomedical addiction model of smoking as self-identity, the identity in Factor Two is oriented around distancing oneself from it. However, there is no attempt to dismiss or challenge the fundamentals of the addiction model. There is strong agreement with items such as *'Health is my number one concern in relation to smoking'* (+6) and *'I know what the doctors say, but I sometimes feel that the risks of smoking have been exaggerated'* (-4) in common with Factor One. Rather this Factor represents identity work for those who do not wish to characterise themselves personally as Factor One's 'addicted, unhealthy, out of control' smoker.

The participants who loaded significantly onto this Factor are predominantly higher SES and in the younger age group (although this is noted as a tendency, not a statistical association). Indeed, there are several features of this Factor which suggest that it is a young, middle-class smoking identity. Previous research has shown that the 'social' identity is particularly a feature of adolescent smoking, representing the non-addicted end of the addiction/identity spectrum (e.g. Amos et al., 2006). Johnson et al., (2003) term this 'social dependence' rather than purely 'social' smoking, indicating that for many young people, they perceive their use of cigarettes as functional at a social level to the extent which they would worry about socialising without them as a social tool. Collins et al., (2002) found that 'smoking as a social tool' was the largest factor (8 participants loading) in their Q-sort of smoking. These smokers felt that they needed their smoking in terms of peer bonding and to facilitate friendships. However, unlike in

this factor, these smokers did characterise themselves as addicted, which may reflect the idea of ‘social dependence’ (Johnson et al., 2003).

In this sample, however, these ‘not really a smoker’ smokers have more in common with the ‘social’ and ‘ambivalent’ adolescents of Amos et al., (2006) with their emphasis on self-control. They draw on a narrative of ‘invincibility’ and distance from others similar to that found in teenagers (Moffat & Johnson, 2001). For example, although they do not dispute the addictive properties of tobacco, the addicted smoker is always the ‘other’ smoker. This suggests that although certain features of adolescent identities, such as the ‘coolness’ (e.g. Denscombe, 2001; Mitchell & Amos, 1997; Plumridge et al., 2002) are no longer a prominent feature of smoking identities for those in their twenties and thirties, other aspects such as being ‘social’ and personally in control, very much are. This is not surprising; thirteen out of the sixteen participants loading onto this factor are in their twenties. This suggests a continuity of smoking identities from late adolescence into the twenties and even thirties for certain groups of young smokers, particularly in this sample, for middle-class smokers.

One feature of this continuity is the emphasis on ‘self-control’. As discussed in Chapter Three, several theorists (Crawford, 1994; Hammersley, 2002) have argued that ‘control’ is a key Western value which is displayed by middle-class individuals through the arenas of health and addiction. Joffe & Staerkle (in press) have suggested that being ‘in control’ and designating the ‘Other’ (smoker) as ‘out of control’ is one of the key features in the creation of damaging negative stereotypes within Western society; correspondingly those seen to be ‘in control’ are ideologically and socially advantaged. The participants loading on Factor Two are highly motivated to distance themselves from the ‘out of control’ smoking identity of Factor One by emphasising their self-agency over their habit. This can be seen in their rejection of the set of ‘powerless’

statements which are found in Factor One. That this is a middle-class smoking identity is also evidenced in their wholehearted rejection of Item 1, '*Smoking is my only luxury*'. Graham (1993a) has shown that this is a statement endorsed by poor single mothers, who feel trapped by their circumstances and cope through smoking. The smokers who load onto Factor Two, however, are clear that smoking is only one amongst their pleasurable 'extras'; a 'life choice' rather than a fundamental 'life necessity'.

Denscombe (2001) has suggested that for adolescents, smoking represents a self-reflexive affirmation of 'who I am' and one's ability to make decisions for oneself in the face of uncertainty about the risks. The smokers loading onto Factor Two here also display a similar sense of self-agency and decision-making which helps their identity continue to 'fit' with the contemporary Western ethos on control. It might be thought that this inability to accept one's smoking in terms of nicotine addiction would make quitting more problematic. If people do not see themselves as personally addicted, they may be less likely to seek help. However, young middle-class smokers, with whom this 'not really a smoker' smoking identity seems most associated in this sample, are precisely the social group most likely to quit (Lader & Meltzer, 2004). Again, perceptions of control may account for this. These smokers have high self-agency with regard to not smoking for periods of time and for quitting in the future. These beliefs are likely to be facilitative in giving up permanently. These smokers also do not regard smoking as fundamental to life, but more of a peripheral pleasure. This might reflect a lower dependence on nicotine (Jarvis & Wardle, 1999). As smoking is not seen as an intrinsic part of the self, but rather something driven by external (social) forces, this also allows conceptually for the idea that smoking can be discarded in the future when the social context changes.

The final Factor which orients around a health risk model of smoking is Factor Six. However, although the two participants that load onto this factor are concerned about their health vulnerability, they reject the idea that smoking is a medical addiction, similar to drug or alcohol addiction. It is unclear why this is the case, as these participants also acknowledge, again uniquely, that quitting smoking would be like losing a best friend and conceptualise smoking as a form of coping mechanism. It may be that the negative connotations of drug use are not something with which they wish to associate themselves (Hammersley & Reid, 2002). They also, perhaps paradoxically, reject the label of 'smoker' despite the deeply embedded nature of smoking in their lives.

Factor Six is termed the 'ambivalent' smoker precisely because it does not appear to represent an internally consistent 'position' or 'identity'. Billig (1987) has written that traditional attitudinal survey methods find it difficult to cope with the inherent uncertainty of people's beliefs as they require the measurement of a 'valid' (i.e. internally consistent) concept. It is certainly one of the strengths of Q-methodology that the 'voice' that is identified by the sort does not have to be consistent in the eyes of the researcher. One would not want to make too much of this point in this context. Factor Six is relatively small with few participants loading onto it. The two factors (One and Two) onto which the majority of participants loaded were strong, internally consistent and easily interpreted positions. However, it does illustrate that if there are complex or ambivalent viewpoints held on a given issue, Q-methodology is an excellent way of accessing them, a point to which we shall return later in the discussion.

The three Factors considered so far represent smoking identities primarily oriented around and accepting of the health risks of smoking and its potentially addictive character. The other three Factors are not, representing different understandings of

smoking and smokers outside the dominant biomedical model. Factor Three, onto which four participants loaded positively and one negatively, is termed here the 'laissez-faire' smoker. This appears to constitute a relatively relaxed smoking identity; there is no need to distance oneself from being a smoker as with Factor Two, nor is being a smoker a matter of disgust and self-hatred, as with Factor One. Many of the common 'stereotypes' about smokers, whether this be that smokers see themselves as sexy and rebellious, neurotic, unhealthy or addicted, are rejected. Although smoking is characterised at a functional level as enjoyable and a way of combating boredom, participants simply don't over-analyse their smoking behaviour.

By way of contrast, the fourth Factor, the 'proud' smoker, encapsulates a very strong smoking identity. Although the functions of smoking are conceptualised similarly to Factor Three (as pleasurable and a way of combating boredom), the two participants loading positively onto this Factor have a defiant smoking identity in which they embrace many of the 'stereotypes' previously rejected. Smoking has connotations of sexiness and rebellion and the smoker is characterised as a 'bon viveur' who knows how to enjoy life. The values of Factor One and Two of health (ism), risk and being in control are also explicitly rejected; rather this Factor represents the valuation of freedom, the rights of the individual to smoke, living for today and living life to the full. This viewpoint might be linked with a left-wing (or alternatively very right-wing non-state interference) middle-class agenda concerning liberalism, the rights of the individual and a live and let live attitude towards 'vices'. However, with such a small Factor it is hard to judge.

These two Factors (Three and Four) encapsulate minority positions outside the dominant biomedical model. This corroborates the findings of Collins et al. (2002) that differential understandings of smoking, based on differential value-systems, can be

tapped well by a Q-sort. This may particularly be the case here as the Q-sort was conducted by a postal system, which is not always the case with Q-methodology. The participants here did not have to rationalise or explain their positions face to face to an interviewer. This perhaps allows these normally unarticulated or 'unsayable' viewpoints to emerge. It is unlikely, for example, that Participant Four who quotes the swearing comic and pro-smoking campaigner Bill Hicks to illustrate his feelings of defiance towards the anti-smoking lobby would have done so in person to an interviewer.

The significance of these Factors for a smoking cessation perspective is harder to assess. They are, as pointed out, minority viewpoints that contrast with an overwhelmingly dominant medicalized understanding. No motivation for quitting appears in either Factor; Factor Three encapsulates a relatively laid-back approach in which there is no real desire to stop being a smoker and Factor Four represents a deliberate choice to be a smoker in the face of the perceived societal erosion of smokers' rights. Jarvis and colleagues (Jarvis, Wardle, Waller and Owen, 2003) has identified what are termed a 'hard-core' of smokers who are resilient to quit messages and attempts. One of the features of this group, as with the smoking identities represented here in Factors Three and Four, is that they simply do not wish to quit. Their research estimates 'hard-core' smokers to comprise about 16% of all smokers, be older, be more dependent on nicotine and also be more socio-economically deprived.

The question of what to do with smokers who express no desire to quit is the subject of some debate. Jarvis and colleagues suggest targeting interventions, taking into account the perceptions of 'hard-core' smokers to more carefully to address what they acknowledge is a 'formidable public health challenge'. However, even if one overcame the objection that smoking cessation should not be a coercive enterprise, it is unclear this would work in practice. Prochaska's five-stage model of addiction recovery

(Prochaska et al., 1992) would suggest that the positions expressed in Factors Three and Four reflect the very first stage, 'pre-contemplation', in which the individual has not really considered stopping. As such, they are not usually the target of sustained smoking cessation efforts on the basis that quitting (either on one's own or with external help) has to have at least some limited motivation to quit as a pre-condition of change.

The final factor considered here, onto which four participants significantly loaded, is Factor Five, termed the 'anti-social, social smoker'. Smoking in this Factor is seen positively as enjoyable, sexy, as a stimulant and primarily a social activity. However, although the smokers themselves see it as such, they also feel that they are thought less of and perceived negatively for being smokers in a wider context. This may well be an identity associated with an older age group; three participants out of the four loading significantly on this Factor were over 50 years old. Interview studies with older smokers (Parry, Thomson and Fowkes, 2001; 2002) have also found that the changing social status of smokers, from acceptable to unacceptable, within their lifetimes is a considerable source of concern and distress to older smokers.

One of the key findings presented in Chapter Six, Seven and Eight was that the theme of stigma and disapproval was a very central and salient theme in the interviews. However, in the Q-sort, the factor which orients around social disapproval (Factor Five) is a small one with few participants loading significantly onto it. There are two points to be made in relation to this seeming disparity. Firstly, although Factor Five is distinctive in its ranking of items relating to the societal disapproval of smokers, other Factors also contain elements of stigma. For example, participants endorsing a smoking identity oriented around the biomedical model (Factor One) view their smoking as disgusting and dirty, reflecting the negative aesthetic dimension discussed in Chapter Six. Participants loading onto Factor Two also identify smoking as dirty, though they are not

personally disgusted by it. As Chapter Six indicated, the stigmatisation of behaviour can be indicated indirectly by multiple aspects. Factor Five in the Q-methodological study represents an identity oriented primarily around one aspect: the perception of external societal disapproval. The notion of the smoker as ‘polluter’, on the other hand, underlies several Factors, although is directly rejected by those who hold alternative smoking identities (Factor Four and Five).

Secondly, the methodology of the Q-sort and interview studies might produce slightly different emphases. In the interviews, the coding of stigma was wide-ranging and often implicit, such as coding the social groups identified with smokers and coding subtle expressions of social disapproval. No explicit question concerning stigma was ever asked in the interviews. The Q-sort items concerning stigmatisation are much more direct and extreme, such as Item 29 ‘*People sometimes do think less of smokers, although they shouldn’t*’ and Item 61, ‘*People have a really negative perception of smokers nowadays*’. It may be that when confronted with these relatively bald statements, the majority of smokers become somewhat defensive. The term ‘people’ also does not allow the participants to distinguish between their own social groups, who may well be accepting of smokers, and other societal groups who may not.

A theme which did emerge more prominently in the smoking identities of the Q-sort, however, is the ‘pleasure’ of smoking. In the interviews, the pleasure of smoking was not often explicitly discussed and only a minority made reference to it. Here, the majority of the Factors (Two, Three, Four and Five), created by the majority of participants, define their smoking as enjoyable.

The fact that smoking is experienced as pleasurable by a large number of smokers has arguably been neglected within smoking research (Graham, 1993, Warburton, 1994). From a smoking cessation perspective, Warburton (1994) has argued that the healthism

agenda may be counter-productive. Making people feel guilty about their pleasures such as smoking may harm their health at a psycho-biological level by inducing stress. He deduces from that that people should be left, in a libertarian fashion, to choose their pleasures or at least not make them feel guilty. Warburton sees pleasure and guilt as fundamentally incompatible; smoking causes guilt which causes stress which is counter to the experience of enjoyment. However, as was argued in Chapter Eight, many pleasures are precisely pleasurable because they are 'bad' in some sense (e.g. Klein, 1993). The strength of the Q-sort methodology in this instance is that it allows these paradoxes, often only hinted at in interviews, to be exposed. In Factor Two, for example, the notions that smoking is both a health risk and a pleasure are held simultaneously within the same position.

One problem, however, with acknowledging the pleasurable nature of smoking is that it might lead to a fatalistic approach to smoking cessation. This is epitomised by the former Government Health minister, John Reid, who has been associated with a view that one ought to leave working-class smokers with their pleasure given their disadvantaged circumstances (BMA News, Sat. 2nd July, 2004). However, as articulated in Chapter One of this thesis, the suffering of smoking is also borne precisely by these poorer groups; an arguably unfair state of social inequality. The Q-sort results here also suggest that pleasure is a key feature of accounts from smokers of different SES groups. Factor Two, for example, is an identity held mainly by higher SES smoking participants. Smoking cessation interventions that can take account of the paradoxical nature of smoking are likely to be more successful than those who simply ignore them or succumb to fatalism in their presence, a point considered further in Chapter Ten.

The final aspect of the results considered here is the issue of class and its relation to smoking identities. Items concerning the class/smoking link were included amongst the

Q-sort Items was because the interview study results suggested that higher SES smokers, although not lower SES smokers, may tend to make such an association. However, the results of the Q-sort indicate that, when faced with Items which directly state there to be a link (Item 10, *'I do tend to associate smoking with poorer or less well-educated people'*, Item 50 *'I think smoking looks down-market, even though I do it myself'*), smokers rank them very negatively. Furthermore, the comments on this topic, which were numerous, show that the majority of this sample strongly disagreed with any suggestion of a link. Rather it was claimed that smoking has an inclusive social identity including people from all social groups. This represents considerable identity work on the part of these smokers; the aim is to demonstrate that smoking identities are socially shared, common-place and cut across social boundaries. Thus one is not distanced from other identities by 'being a smoker'.

The reasons for the difference between the Q-sort and the interview results may be several. Firstly, only a sub-set of the smoking participants (primarily higher SES smokers) in the interviews made such a link. Secondly, the conceptual map asked for free associations, which may have been more unconsciously produced. The interview context also allowed participants to position themselves identity-wise away from this association if they made it. Finally the Items chosen to express the link in the Q-sort may not have been nuanced enough. It is interesting that the more subtle Item, 50 (*'I think smoking looks downmarket even though I do it myself'*) was ranked more neutrally by Factor One and Two than the far more direct statement Item 10 (*'I do tend to associate smoking with poorer or less well-educated people'*) which all participants ranked very negatively. This is something that could be corrected in future studies by asking a greater number of smokers to review the initial Items before selection.

This is not to say that the results of the Q-sort are invalid. It is certainly a striking finding that this sample reacted so strongly and negatively to the suggestion of a link between smoking and social position. This suggests that as an issue it is highly salient for smokers and one which arouses strong emotion. What is also suggested is that mixed methodology produces interesting contrasts as a consequence of different aspects of the methodology, such as the level of social interaction, the flexibility of the parameters of what can be said and not said and the type of task. These differences in results can then be used to build up a more complex picture of a phenomenon, in this instance the perceptions of a class-smoking link in the lay population.

Finally, one must consider the nature of the sample and the implications in terms of comparativity with similar or related research. As discussed in Chapter Four, one of the motivations for conducting this research was to include participants of diverse socio-economic status given the social patterning of smoking (Jarvis & Wardle, 1999). The only previous Q-methodology study on smokers' representations of smoking (n=36) did not specify the SES of participants. Their mean age was 28. Out of their four main factors, two of them 'smoking as a social tool' and 'smoking as a social event' orient around the social meaning of smoking, and in a third 'the dual identity smoker', smoking around other smokers is a significant feature, though smoking was not part of their background. This suggests perhaps a relatively young, middle-class sample, where 'social smoking' is still the primary feature, as discussed earlier.

The characteristics of the research participants in this Q-sort also constitute a distinct sample in several senses. Firstly, just over a quarter of the sample (17 out of 64) are home-based participants not in traditional employment. They are either caring for children (n=8) or on long-term disability or unemployed (n=9). This constitutes a group who, by their self-report, smoke relatively heavily and are dependent, smoking

immediately on waking. This may explain to some extent the dominance of the ‘addicted, unhealthy, out of control’ first Factor in this Q-sort. More females than males also responded to the adverts, which is a common feature of social research.

The wide range of socio-economic/employment status in the sample can be considered a positive feature of this study. However, it proved difficult to attract lower SES participants even with specific targeting in newspapers with a predominantly C2DE (lower SES media classification) readership, in line with other research with disadvantaged participants (Bancroft et al., 2003). Consequently, even with the presence of a sub-group of home-based individuals caring for children with no previous occupation/benefits/unemployed, only 42% of the smokers in this study fall into the lower SES category (with 58% in the higher SES ‘professional’ group). Although in this study, the aim was not to ‘represent’ the UK population in any statistical sense, it is worth noting that higher SES smokers make up just over half of those who responded. This is not the case in the overall population, where smoking rates are over twice as high for manual workers as for professionals (Lader & Melzer, 2004; Goddard & Green, 2005). Factor Two in particular appears reflective of a young, middle-class identity in relation to smoking. As with all qualitative research, the Q-sort produced here is reflective of the characteristics of these participants in particular and this must be borne in mind as a limitation when interpreting the results.

Conclusion

In conclusion, six clear ‘smoking identities’ were found within the Q-sort. Three of these orient around the dominant biomedical model of smoking as an addictive health risk; the ‘addicted, unhealthy, out of control’ smoker (Factor One), the ‘not really a smoker’ smoker (Factor Two), and the ‘ambivalent’ smoker (Factor Six). The other three reflect different understandings and values in the creation of smoking identities;

the ‘laissez-faire’ smoker (Factor Three), the ‘proud’ smoker (Factor Four) and the ‘stigmatised’ smoker (Factor Five). Thus, the Q-sort clarified how many of the discourses and themes discussed in the interviews translate into discrete identities with a distinct ‘position’ on ‘being a smoker’. Other discourses, such as the pleasure of smoking, achieved more prominence through this methodology. Further investigation of the class-smoking link in lay understandings of ‘being a smoker’ revealed that it is an issue of high salience, but is hotly disputed by smokers, perhaps due to the identity-threatening nature of the association. It is argued that taking into account smoking identities and the conceptual understandings underlying them may be important, particularly when tailoring interventions for different SES groups.

CHAPTER TEN:

CONCLUSION

'Anti-smoking forces in this country have not yet succeeded in banning cigarettes, only in changing the value of the signs that surround them'

Klein (1993) 'Cigarettes are sublime', p16.

10.1 Introduction

This chapter has four sections. The first highlights some of the major findings of this thesis. The second looks at the distinctive choice of methodology, its advantages and limitations. The third section considers the changing social context in which this research is located, leading to exploration of the implications of the findings for health promotion. Finally, section four considers the distinct contribution of this thesis for the literature.

10.2 Major findings

The starting point of this research is the epidemiological evidence of the 'poor smoker' phenomenon. As Chapter One shows, poverty is intimately related to high smoking rates (Lader & Meltzer, 2004; Jarvis, 1997). This is linked to the differential socio-economic trajectories of more and less advantaged groups, which are entwined with their smoking careers. Greater numbers of low income individuals start smoking, progress to regular smoking, and fail to quit smoking in an accumulation of disadvantage (e.g. Jeffries et al., 2004b)

In Chapter Two, this thesis offers a strong critique of existing psychological explanations of the class differentials in smoking. It is argued that a biomedical addiction model has come to dominate the health psychology of smoking. This model now constitutes the primary functional explanation of smoking (e.g. Pomerleau & Pomerleau, 1984; 1989) and the basis for intervention (West, McNeill & Raw, 2000). However, it lacks explanatory power in the face of class differences in smoking. In

particular, the focus on smoking at an individualistic, biological and genetic level has led to the exclusion of important 'macro-social factors' (Joffe, 1996) such as meaning-systems and identities that may particularly be implicated in the social patterning of smoking.

Explanations based on the Knowledge, Attitudes and Beliefs Paradigm (KABP) can be similarly criticised. The KABP characterises smoking to be a product of rational decision-making, particularly over health risks. There is an inherent tension between this presumption of rationality and the biomedical addiction approach which presupposes the smoker to be 'out of control'. Research based on the KAPB has also not proved productive in the face of class differences. There are equally high rates of knowledge of the health risks across all classes, and these tend not to predict cessation rates (van der Plight, 1998). Furthermore, although the KABP does contain some theorisation of the 'social', this tends to be at a micro-social level, referring the immediate environment of the individual smoker, rather than at the macro-social level theorised to be relevant.

Not all smoking research has ignored social factors. The structural account of smoking provided by Graham has also been critiqued (1993a; 1993b; 1994; 2003). Graham's mixed methodology research was conducted with poor lone single mothers. It highlights well the alternative discourses, such as smoking as a coping-mechanism or a 'luxury'. However, the lack of comparison in interviews with other social groups (such as middle-class smokers or non-smokers) leaves some question-marks over the hypothesised causal account of the inevitability of smoking amongst the disadvantaged. For this reason, the interviews conducted as part of this thesis include higher and lower SES smokers and non-smokers as a basis for comparison.

This thesis offers, therefore, a different theoretical basis for considering the ‘smoking gap’ between the classes. It takes a social psychological approach drawing particularly on the concept of ‘social identity’ or ‘identities’. It is important to note that this research is envisaged as complementary rather than competing with existing bio-behavioural research. Such research has made significant contributions, such as drawing attention to the pharmacological effects of nicotine. Yet it offers only one level of explanation, one which struggles to explain differences in the social patterning of smoking.

This thesis has made use of identity theories in a number of ways. The theoretical basis for considering smoking as a social identity comes from Social Identity Theory/Self-Categorisation Theory (Tajfel & Turner, 1986). Identity is understood as part of one’s self-concept which derives from group membership. Thus ‘being a smoker’ or indeed ‘being a non-smoker’ is understood in this thesis as a salient group membership; the basis for ‘smoking identity’ or, as they may be multiple, ‘identities’.

Although social identity tells us who we are, it also says something to other people. SIT/SCT theorises that group membership is subject to emotions and values. It is clear, from the results presented here, that membership of the category ‘smokers’ or ‘non-smokers’ can be considered a ‘signifier’ in this sense. This is shown in the conceptual map task, where, when confronted with two blank sheets of paper, participants were able to spontaneously produce complex images of smokers and non-smokers. For many non-smokers, for example, ‘being a smoker’ constitutes the basis for generalised value-judgments such as being out of control or lacking achievement and emotions such as disgust. It is these ‘signs’ surrounding being a smoker, alluded to by Klein’s quote at the start of this chapter, which have formed the substance of this thesis.

This thesis also draws strongly on the theorisation of group processes provided by SIT/SCT (e.g. Brown, 2000). Indeed, these processes, such as positive/negative social

comparisons, differentiation between and within groups, group variability and social creativity, are all specifically coded within the interviews. This allows the identity work of the lower and higher SES participants to be directly analysed. The identity protective strategies of groups with higher social status are relatively well-theorised within SIT. There is plenty of evidence in the results of these, for example, non-smokers frequently utilise positive social comparisons between themselves and smokers to bolster their own social identity.

Brown has argued that one acknowledged weakness of SIT is that it does not predict which strategies will be used by subordinate groups in given situations (Brown, 2000). What this thesis tends to suggest is that smokers, as members of a subordinate social group, use a variety of strategies in quite complex ways. For example, many lower SES smokers use perceptions of group variability ('although smokers are often unhealthy, we are not all unhealthy'), alongside differentiation within the group ('I do smoke, but not as much as some single mum's I know') and social creativity ('At least I know how to enjoy myself'), as well as negative derogation ('I know I look bad from smoking'). Billig (1987) has argued that people's thinking is not necessarily internally consistent. Smokers in the interviews often both bolstered and denigrated their identity in the same sentence. The minimal-group paradigm, which has tended to be the experimental test-bed for SIT, does not allow multiple situations and strategies to be tested at once. Real-group research, such as presented here, suggests that the relation between situation and group process may be more complex than traditional SIT implies.

SIT research based on the minimal-group paradigm has also tended to neglect social context (Campbell, 1997; 2000). In line with Campbell's constructivist re-working of SIT/SCT, this thesis argues that social environment is key to understanding smoking identities. However, it is important to provide a basis for comparison between social

contexts if one wants to make deductions from them. For example, this thesis shows that most smokers understand their smoking in terms of a response to the stress of their lives, not just lower SES smokers as perhaps Graham (1993a and b; 1994) has implied. However, they do so differentially in response to the different social context afforded by their existing social status and values. Thus higher SES smokers emphasise smoking as a response to a 'work hard, play hard' high achieving workplace, whereas lower SES smokers see their smoking as an emotional stress-reliever in response to problems such as ill-health, caring for children, or even the monotony of manual work. Without a comparison, it is difficult to tease out what is unique and what is common amongst the accounts from different class groups.

This real-group research has also highlighted something neglected in experimental SIT research: the interaction of identities. Smoking identities exist in the context of other identities. Indeed, it is at the boundaries of these, where the interaction occurs, where much of the interesting identity work takes place. Tajfel and Turner (1987) tell us that multiple identities exist and interact fluidly; however, little research has delineated how this might occur. It is suggested here that the interaction of identities is key to understanding differences in health behaviours. The congruence, or otherwise, of one's identities is important and motivational for individuals. For example, the higher SES smokers were highly motivated to prove that they could be both 'healthy' and a smoker. The incompatibility, at the level of fundamental values, causes them much dissonance which may motivate their quit attempts. On the other hand, smoking identities seem to fit, again, at a fundamental value level, with the socially devalued identity of the single mother. Being stigmatised for smoking when one is already stigmatised may do little to promote behaviour change.

The idea that behaviour change might be motivated if one's identities collide is not a new one within clinical psychology. For example, the addict is theorised only to take steps to relinquish their addict identity when it becomes incompatible with other social identities which they risk losing, such as being a partner or employed (e.g. Waldorf & Biernacki, 1981). However, little research has considered how this might play out within the context of smoking, which this thesis has aimed to rectify.

Although concepts from SIT/SCT have been used extensively in this thesis, as a theory it tends to focus on generic group processes. This thesis has also drawn, therefore, on the work of cultural theorists such as Crawford (1994) on health and Hammersley and Reid (2002) on addiction. The reason for this is that their theories have a strong ideological dimension, perhaps lacking in SIT, which is specific to the current socio-political context of the West. They both theorise that middle-class groups have a strong vested interest in identifying the 'unhealthy' and the 'addicted' as the immoral and socially inferior 'Other'. These theories, though not specific to smokers in their origin, are particularly useful here. They explain why the current value of the 'signs' surrounding smokers might be low; smokers in many ways transgress current key Western values concerning health, control, achievement and self-discipline.

One problem with research within a social identity paradigm is that it rests on the researcher's assumption that the identity under scrutiny, such as being a smoker, is salient and important to participants. To this extent it is vulnerable to a similar criticism to that made of the minimal group paradigm which assigns identity experimentally and thus to groups which may not be meaningful outside a laboratory (Campbell, 1997; 2000). One advantage of using a qualitative methodology and studying 'real-life groups' is, however, that one gets feedback in this regard. For example, many participants reported difficulties in producing detailed conceptual maps of non-smokers,

suggesting that the salience of non-smoker identity is considerably less than that of smokers.

Having critically considered the use of social identity theories in this thesis, this discussion now turns to the applied findings. The first key finding is the existence of a core homogenous image of a 'smoker' which is predominantly negative. Being a smokers is associated with being unhealthy, addicted and stressed, with a strong negative aesthetic dimension. Only the social aspect of smoking mitigates the negative image. Although participants from different groups draw on this image differentially, to defend, accept or make use of it in line with their existing social identities, it is important to note that much of this identity work is reactive to the core negative image. In this schema, non-smokers are seen as normative, the benchmark of health and positive life values against which smokers are measured and found wanting. It is smokers, therefore, who have to account for themselves and their actions.

Another key finding is that the dominant biomedical addiction model of smoking is strongly reflected in participants' accounts. For example, in the interviews (Chapter Seven), it is shown that participants draw extensively on bio-medical and scientific discourses to explain smoking. Participants also make use of 'drug language' such as 'drugs' 'users' 'drug addicts' 'going cold turkey' 'hit' or 'fix' and locate smoking on a 'continuum' of addictions. The dominance of the biomedical addiction model is also evidenced in the Q-sort, with the majority of participants loading onto the first two factors, both of which orient around this particular understanding.

It is not surprising that smoking identities are viewed through this medicalized prism. At the widest level, as Crawford has pointed out, health is one of the pre-eminent values in contemporary society (Crawford, 1979). It is argued that the biomedical model of smoking accords well with this as it places the threat to health through addiction at the

heart of the model. However, it is worth noting that this model is not uncritically accepted by lay people. Many participants in the interviews introduce the addictive properties of smoking as a contested fact rather than something they take for granted. This perhaps reflects the relatively recent, and controversial, classification of smoking as an addiction on a par with hard drug use although its risk to health has been longer and more uncritically acknowledged (RCP, 2000).

This raises the issue, at a social identity level, of what the consequences might be for smokers of conceptualising them through a biomedical addiction model. One consequence is that it draws smokers into the conceptual sphere of being an ‘addict’. As Hammersley and Reid (2002) have argued, the ‘addiction myth’ utilises the character of the ‘addict’ as an illustration of how not to behave. The addict (who fulfils a similar function to the ‘Unhealthy Other’ identified in Crawford’s thesis) epitomises the transgression of moral boundaries such as being unhealthy, out of control and having little personal responsibility. In this instance, the medical re-characterisation of the smoker as an ‘addict’ links smokers with the ‘spoiled’ identity of harder drug users (Waldorf and Biernacki, 1981) rather than the ‘fun-loving’ identity of a pleasure-seeker, and thus the attendant moral judgements that accompany them.

This ‘spoiled’ identity is the basis of much social disapproval of the smoker. Another key finding in this thesis is a pervasive seam of stigmatisation running alongside the biomedical addiction discourse. Particularly striking is the identification of a strong negative aesthetic comprising smell and poor appearance. The smoker literally and metaphorically is seen as bearing the ‘marks’ of the stigma on their bodies. These ‘markers’ allow non-smokers both to identify the smoker and react to them, usually with negative emotions such as disgust.

The key metaphor that appears to be driving the current stigmatisation of the smoker is that of 'pollution'. As Douglas (1966) has written, dirt can be a defining feature of the 'risky' and thus the 'bad' in our culture. Smokers, according to non-smokers in particular, transgress modern-day pollution rules. In the negative aesthetic discourse in the interviews and Factor One of the Q-sort, the smoker is identified as 'dirty' and 'unclean'. Furthermore, through the act of smoking, they contaminate others through passive smoking. Their contamination 'threat' is very high particularly towards those who are considered blameless or 'innocent', such as children. As such, they are blamed and stigmatised for their behaviour. Both smokers and non-smokers also use the pollution metaphor to describe the effects of smoking on the body; the smoke is described as a 'toxin' which contaminates their body. This is one reason why the higher SES smokers are keen to emphasise their detoxification regimes in the face of this pollution. It offers, at a symbolic level, a possible way to re-create their social identity as 'pure'.

Stigmas are a combination of both material and symbolic threat (Stangor and Crandall, 2000). It is argued that being a smoker appears to embody a threat on many levels. All attempts to calculate the realistic threat from passive smoking to others are viewed through the symbolic prism of a threat to purity and the transgression of moral values. Thus, following Goffman, it can be argued that smokers have a 'soiled' as well as a 'spoiled' social identity in contemporary Britain.

One interesting finding, which might mitigate this argument, is that the stigmatisation discourse is not, at first sight, as salient in the Q-sort as in the interviews. One identity, the 'Anti-social social' Smoker (Factor Five) does orient around external social disapproval, however, this is a minority position. Several points can be made here. Firstly, although Factor One does not orient solely on the dimension of stigma, the large

number of smokers who loaded onto this factor do agree strongly that their behaviour is disgusting and that smoking is dirty. In this Factor, therefore, the medical and scientific discourse concerning the inhalation of toxins is conceptually entwined with notions of symbolic self-pollution.

Secondly, this lack of emphasis on stigmatisation may be a function of the different methodologies. In the interviews, stigmatisation is assessed indirectly by the researcher on the basis of the theoretical stigma literature. Thus its presence is deduced through the extent to which it meets the criteria of stigma (Jones et al., 1984; Stangor and Crandall, 2000; Goffman, 1963). In the Q-sort, the sample of smokers is asked directly to rank items on stigma and to comment on them. It may be that when confronted with the notion that smokers are stigmatised, many smokers find this a threatening concept. They may not wish to orient their identity, smoking or otherwise, around the concept of social rejection. The interview study may also tap, through the free associations produced by the conceptual maps, less conscious material such as moral judgements which are politically incorrect.

Another key finding in this thesis is that the response to the designation of a 'spoiled' smoking identity appears to differ between class groups. Throughout the interviews and in the Q-sort, higher SES smokers tend to challenge the dominant discourse and distance themselves from this negative social identity. They dispute the 'facts' of their risk to others, for example, as well as making mitigating comparisons between their own polluting behaviour and that from other sources, such as environmental. They tend to characterise themselves as 'social' smokers, designating 'Other' smokers as the ones who are stressed out, addicted and unhealthy. They also tend not to label themselves using stigmatising terms such as 'outcasts'.

Many of the social identity processes higher SES smokers evidence, such as distancing themselves from the negative aspects of smoking identities, can be viewed as a way of maintaining their threatened social status. However, this incompatibility of identities may in fact be beneficial for middle-class smokers keen to give up smoking. It has been theorised that addicts only change their behaviour when their identities become incompatible with others they value, such as being a mother or being a worker (Waldorf and Biernacki, 1981). Giving up smoking allows higher SES smokers, therefore, to move to a more coherent social identity that is valued highly within their social milieu.

Although lower SES smokers occasionally challenge the dominant discourse, they also show much more acceptance of it. Throughout the interviews, the lower SES smokers are more likely to label themselves as stressed out, addicted or unhealthy, with the attendant connotations of an inability to cope and a loss of control. They also tend to blame themselves for posing a risk to others as well as exhibiting feelings of powerlessness in the face of their own personal risk. As Chamberlain and O'Neill have pointed out, feelings of powerlessness and a lack of self-efficacy on the part of lower SES individuals are not necessarily illusory (Chamberlain and O'Neill, 1998). Lower SES smokers are more likely, for example, to experience ill-health or to be dependent on nicotine (Jarvis & Wardle, 1999).

It is theorised here that, at an identity level, this internalisation of a negative smoking identity by lower SES smokers may also be the consequence of multiple stigmatisations. Research has shown that being 'poor' is already stigmatised, having connotations of laziness or lack of forward thinking (e.g. Furnham & Gunter, 1984; Ryan, 1971). As Chapter Six demonstrates, the smoker is often identified by non-smokers in particular with a number of stigmatised groups, such as those at the extremes of age, females, and the working-class/disadvantaged. These stigmas are then combined in a number of ways

into images which are used to epitomise social and moral transgressions. The most striking example of this is the poor single mother who smokes around her children. The interviews reveal her to be judged as morally culpable for her failings, which are thought to include harming her children, misusing her money and being socially irresponsible. The connotation is of a loss of control, not just over smoking, but over one's life in general. Those who hold these multiple 'Other' identities, such as 'poor smokers', are likely to be multiply stigmatised. The consequences for this in terms of health promotion are considered in the final section.

Another key research question outlined in Chapter Three is whether lay people themselves are aware of the 'poor smoker' phenomenon and, if so, how they construct it in the light of their own social status. The initial results from the interviews suggest that certain sections of the population are certainly aware of it. Non-smokers in particular identify the poor, working-class, uneducated and disadvantaged as groups with high numbers of smokers. Approximately half of the higher SES smokers also make such a link, although in an identity distancing strategy, they tend to argue that this comes from media sources rather than their own personal experiences. Only the lower SES smokers tend not to make this association, perhaps because it is a negative identity rather close to home.

Having established that many lay people do make this link between class and smoking, it was decided to include items to reflect this in the Q-sort. However, every item that suggested a link is ranked negatively by the participants. Furthermore, on examining the comments, the participants disagree emotively and strongly with such a suggestion. They argue that far from being associated with poverty, smoking has an inclusive social identity; 'all sorts of people smoke'. The explanation for this seeming difference may be methodological. The items in the Q-sort are relatively blatant about the link. It may be

that the interview context allows smokers to be more nuanced and make their own identity clear in relation to the link. The interview is also based on the free associations tapped by the conceptual map. This may allow the exposure of less conscious, politically incorrect material. It may also be the case that the reaction of the smokers to these items in the Q-sort is a defensive one. Well aware that there is an association between class and smoking in the minds of non-smokers at least, they react in an identity protective way. It is suggested, therefore, that for the middle-classes (mostly non-smokers), smoking is increasingly understood as a 'marker' of social disadvantage much as it is within epidemiological research. It is becoming a short-hand, external, signal of poverty, a way of identifying the 'poor' and their 'bad', risky behaviour to the moral majority.

As the prior discussion indicates, the smoking identities that emerge from this research are predominantly negative. Alternative discourses surrounding smoking, such as smoking as pleasure and smokers as social/glamorous are present, but somewhat sidelined by those of addiction, health risk and social disapproval. It might be argued that to a certain extent, this is an artefact of the situation. Participants may perceive the researcher as a health professional and therefore give a socially 'acceptable' account of smoking as a biomedical addiction. For example, where the researcher was not present in the Q-sort, pleasure is ranked highly in four of the six Factors. This makes it appear as a more dominant theme than in the interview analysis where the researcher was not present. However, other discourses, such as that surrounding the sexy, rebellious and creative smoker embodied by Factor Four's 'Defiant Smoker' reflect minority positions as indeed they do in the interviews. This should not surprise us. The dominance of the biomedical discourse means these discourses may be relatively unarticulated even within people's own internal dialogues. Their lack of articulation may reflect an

internalisation of dominant social values rather than necessarily a methodological problem.

The most positive aspect of smoking identities, shown in the conceptual map, is the image of the smokers as 'social'. This notion of the smoker as the epitome of sociability and 'having a good time' is entwined with glamorous images drawn from the media. These social/glamorous media images tend to be mentioned less by lower SES participants. It may be that these images of smokers are more salient to middle-class groups. Higher SES smokers tend to define their smoking as 'social' whether or not it meets with the criterion for dependence. Such a characterisation externalises the activity as a response to environmental pressures rather than internal compulsion. It thus distances them from the negative associations of the addicted smoker.

The media images contained in the maps and interviews tend to be drawn from the past, such as Bogart and Bacall, rather than contemporary figures. The connotation is of past, rather than present, glamour. It is interesting to note that although theorists such as Klein (1993) have written extensively about the working-class smoker between the wars and the media stars whom they idolised, the lower SES smokers of today make little mention of them. Klein perhaps idealises the working-class smoker of yesteryear, in contrast to the social stigmatisation they receive today.

10.3 Reflections on methodology

The research presented in this thesis utilised a distinctive mixed methodological approach. Three methodological tools were used to explore smoking identities in relation to class. The first was a conceptual map, used to tap initial spontaneous thoughts which may reveal less conscious, symbolic material (Joffe and Lee, 2003). The second was an interview based on narrative principles to explore the terrain in considerable detail (Flick, 1998). The third was a Q-sort study which clarifies and

separates the discrete ‘positions’ that emerged from the interviews (Brown, 1980). The advantages of the methods used here are considered first, followed by some of the potential criticisms.

These methods were chosen for their complementary nature with the emphasis on ‘giving voice’ to lay people’s understandings of the phenomenon in question. The conceptual map and interview were conducted together, with an *a priori* sampling of lower and higher SES smokers and non-smokers (n=40). The Q-sort was conducted subsequently (n=64). This meant that the Q-sort items could be drawn from the salient topics from the interviews. The two methods were envisaged as complementary. Thematic analysis of interviews necessarily leads to the division of material into macro-categories, or themes. This can mean, on occasions, that the inter-relations between the categories are not the focus of attention. The Q-sort allows participants to give an account of their smoking identity in a holistic sense, drawing many themes and attitudes together. It thus represents an extension of the first study rather than a replication via a different methodology.

These methodologies incorporate both qualitative and quantitative elements. The conceptual map is analysed in terms of percentages which offer a numerical ‘span’ of the dimensions of smoking identities. The interviews are not presented in terms of percentages, but add qualitative depth to the ‘span’ of smoking identities. The Q-sort constitutes a quantitative factor analysis, but relies heavily on a qualitative interpretation of the factors (Brown, 1980). As discussed in Chapter Four, the traditional criteria of ‘reliability’ and ‘validity’ are not necessarily conceptually appropriate for research conducted in the constructivist tradition (Yardley, 2000). Triangulation is not a way of removing the ‘bias’ of subjectivity, but paying respect to it by accessing different perspectives. It is hoped that the research presented in this thesis is more detailed, more

complex and thus is more likely to be both credible and plausible as a consequence of its triangulation (Silverman, 1993).

The utility of the conceptual map is now considered. It was argued in Chapter Four that a task such as this, which prompts spontaneous ‘off the top of one’s head’ associations may access less rational, less conscious and more symbolic material (Joffe and Lee, 2003). There is some evidence of this. The maps saw the emergence of a very strong negative aesthetic dimension to smoking identity, with notions of dirt, pollution and contamination, all of which resonates at a symbolic level. The access to less rational, more symbolic material may occur for two reasons. Firstly, the task is quick and immediate; there may be less time for rational processing to occur. Secondly, the researcher is not present. This may encourage participants to put down their spontaneous thoughts without having to account for them rationally to a researcher. As the conceptual map discussion shows, participants do not appear to feel constrained by political correctness when describing their images of smokers. However, it is difficult to know whether this is a function of the free association method or a measure of how acceptable it is to openly stigmatise smokers.

The conceptual map instructions also ask participants to include drawings if they wish, again to encourage less rational and symbolic material. However, the production of drawings proved a double-edged sword in terms of producing analysable results. The few drawings that were produced do appear to draw out salient symbolic images, of glamorous movie stars or of Death itself. However the lack of quantity means that no firm conclusions can be drawn from them and thus their utility, in this study at least, is somewhat diminished.

The structure of the interview is very much based on the maps, with the researcher led by the participant through the material. This allows the salient issues to emerge, using

the terms which the participants themselves find meaningful. To take an example, one unanticipated finding was the prevalent use of ‘drug language’ by participants, speaking about smoking in terms of a ‘hit’, ‘fix’ or ‘withdrawal’. This may reflect the drawing of parallels between hard drug use and smoking by health professionals keen to have smoking accepted as a biomedical addiction. It is arguable that this type of nuanced analysis of language is only possible where the interviewee is relatively free to form their initial thoughts and words with the minimum of interference from the researcher through a tool such as the conceptual map.

The narrative nature of the interviews also allows the ‘voice’ of the participant to emerge. It has been argued convincingly that solely semi-structured interview that ask about the ‘what?’ ‘how?’ ‘where?’ and ‘why?’ tend to elicit mainly abstract and rationalised thoughts (Holloway and Jefferson, 1997). It was decided, therefore, that the interview method should encourage narrative data, such as stories, instances and examples. Traditional narrative interviews can last many hours and lead to quantities of data unsuitable for cross-group comparison (e.g. Schuetze, 1977). An ‘episodic’ interview structure is used here, therefore, which specifically requests personal ‘episodes’ in relation to the topics identified (Flick, 1998). This grounds the data firmly in the experiences and lives of participants. For example, looking at the association between class and smoking identified in the conceptual map, middle-class smokers go on to cite ‘media sources’ as the basis of this association in the interviews whereas middle-class non-smokers claim this reflect what they observe in their daily life. It could be argued that a good interviewer with any semi-structured interview format should encourage narratives. However, the advantage of the ‘episodic’ structure is that it makes this process explicit to both interviewee and interviewer and the data richer as a result.

Another advantage of the 'episodic' interview, followed by a qualitative thematic analysis, is that it allows spontaneous material to emerge. The most striking example of this is the emergence of the strong negative aesthetic surrounding smokers, with connotations of pollution and contamination. This was not entirely expected by the author. In the light of a medicalization hypothesis concerning smoking research, it might have been thought health as a topic would dominate. However, using a text-based computer package allows one to quantify mentions of a topic. This revealed that implicit social disapproval is mentioned a similar number of times to the health effects of smoking. Subsequent qualitative analysis of the interview material revealed a very strong emotive reaction, primarily disgust, to this negative aesthetic. It is arguable that with a more rigid and less open-ended interview structure, the stigmatisation discourse would not have emerged as strongly as it did.

The potential for findings which reflect the assumptions of the participant rather than the researcher is also an advantage of the Q methodology used in the second study. The results of this study show evidence of the emergence of new or less salient 'voices'. For example, the Q-sort reveals the pleasure many smokers get from their smoking, with it being ranked positively in four out of the six factors. The fact that smoking is experienced as pleasurable by a large number of smokers has been neglected within smoking research (Graham, 1993, Warburton, 1994). This may be because the biomedical risk discourse of health professionals tends to drown out other discourses. The Q methodology, particularly with the researcher absent, may allow alternative or unarticulated sentiments, such as the pleasure of smoking, to emerge.

As outlined above, this thesis triangulates research into the smoking 'gap' between the classes by using three methods. This offers an interesting basis for comparison. On occasions, the different methods do produce different results. However, this is not taken

to indicate that one of them is 'wrong'. Rather, it serves to highlight that all methodologies produce certain demand characteristics. A face-to-face interview has the positive that the interviewee can respond dynamically to the questioning, thus allowing themselves to 'position' themselves in relation to topic. The downside of this is that they might feel they have to 'account' for their remarks. This may produce a 'publicly acceptable' rather than a 'private' account. Equally, a Q-sort allows people to sort their attitudes according to their own structuring of the topic rather than that of the interviewer. However, the words of the items are not their own.

An example of this is the findings on the association between class and smoking, as conceptualised by participants. In the interviews, approximately half the higher SES smokers make such a link. In the Q-sort, however, nearly all smokers from every SES group reject such a link. The interviews may have given smokers the opportunity to mention their awareness of a link, but to distance themselves from it. However, when confronted with the link stated directly in a Q-sort statement, they react to it defensively, which may illustrate the identity-threatening nature of the association. These differences also illustrate the point of Billig (1987) that people do not necessarily have a consistent 'position' on a topic. Their 'internal deliberation' can be internally inconsistent and also contrast with their 'external' stance on the matter.

As in all qualitative (and quantitative) research, the parameters of the sample also present limitations of the findings and the conclusions one might want to draw from them. There were two research samples here, which were outlined in some detail in Chapter Four. In summary, unlike in many investigations into smoking and the disadvantaged (e.g. Bancroft et al., 2003; Graham, 1993a; Stead et al., 2001), this study sampled both lower and higher SES groups. In the interviews, the lower SES groups were very much 'working' working-class in that few long-term unemployed individuals

were included (4 out of 20 lower SES were currently not working). This may differ from other samples, such as Bancroft et al. (2003) where there were a greater number of 'not working' participants (34% of men, 48% of women). The interview sample here may thus be more relatively advantaged compared with the long-term unemployed and not represent the poorest in society. However, they correspond to the 'semi-skilled' or 'unskilled' definition of lower SES used in other comparative studies (Chamberlain & O'Neill, 1998). A greater proportion of the Q-sort sample was home-based either through disability, unemployment or caring for children, reflecting their availability to complete this task (40% of lower SES and 16% of higher SES).

This interview and Q-sort samples also had a wider age range (20-60 years of age) compared with some other studies of low income smokers (e.g. Bancroft et al., 2003 age range of 25-40 years; Stead et al., 2001, age range of 20-45 years). Although age differences have not been the primary focus of this thesis, it is clear that the findings are linked to age (e.g. the second Q-sort factor was almost exclusively loaded by higher SES participants in their twenties). Notions of 'social' smoking, and identities oriented around this definition, are linked to a younger age group and possibly class. This is an interesting area to explore in further research. On the other hand, the largest factor in the Q-sort, representing the 'Unhealthy, Addicted, Out of Control' smoker was sorted significantly by a wide-cross section of participants ranging in age and SES, suggesting this influence of the dominant biomedical understanding of smoking is not exclusive to one socio-economic group, or one age group, in society.

The method of recruitment also will have influenced who made up the research samples. For example, it was difficult to recruit lower SES participants. This was not for the same reason as Parry et al., (2001) who found the records of lower SES participants less complete. Rather here, there was a response bias on the part of higher SES participants,

even when adverts were placed in newspapers which had a strong working-class readership for the Q-sort. Similarly, in circulated emails to offices with both professional and semi-skilled/unskilled workers, more professionals came forward. To encourage a greater number of lower SES smokers to participate, smokers who had not attended but had registered with a smoking cessation clinic serving North London were approached. Several of the lower SES women in the interview sample came into the study via this route. This may mean that they were more concerned with quitting than other lower SES women and may have had a more bio-medical understanding of smoking focused on health and addiction.

10.4 The research in a wider context; health promotion and social change

It has not been the intention of the thesis to focus too heavily on the health promotion aspect of smoking cessation. However, the findings have application in a wider context. This section reviews some of the implications for health promotion and considers how a changing social context, particularly the impending ban on smoking in public places in the UK, may change the social identities surrounding smoking and, consequently, health promotion based on them.

A key finding of this thesis has been the salience of the stigmatisation of smokers. It was argued in Chapter Six that the attitude of government towards smokers exacerbates this stigmatisation, for example, through the 'Ugly Smoker' ('You smoke, you stink') HEA campaign which has run since Spring 2005. This plays directly on the stigmatising marks and negative aesthetic identified by participants in this study. It is unlikely that any other health behaviour would be targeted in this way, reflecting the lack of political correctness surrounding the disapproval of smokers. However, it could be argued that such stigmatisation is functional from a public health perspective. It has been shown in

the States, for example, that an unfavourable smoking climate encourages quit rates (Kim and Shanahan, 2003).

It is argued here, however, that a campaign based on the negative aesthetic and stigmatised nature of smoking may not be effective for the very group who are the focus of governmental targets: the ‘poor smoker’ themselves. The results in this thesis suggest that smokers from different SES groups may react differently to the existence of a predominantly negative smoking identity. Middle-class smokers, who perceive themselves to have considerable control over their smoking, may be motivated by the desire to distance themselves from it. Quitting represents an opportunity to re-create their identity positively in line with other identities which are valuable to them, such as being seen as healthy, in control and attractive. Lower SES smokers, on the other hand, tend to internalise many aspects of the negative smoking identity. They also exhibit feelings of powerlessness in relation to smoking. They may therefore simply accept the negative aesthetic of smoking as a price that they pay for their behaviour, but one over which they perceive they have little control. Furthermore, lower SES smokers are multiply stigmatised. Already deemed socially ‘unworthy’, smoking may simply be one more dimension on which they feel they fail to meet the dominant moral or social standard. Campaigns based on stigma may confirm to lower SES smokers their devalued social identity rather than motivate them towards the intended behaviour change.

This leads to consideration of what might work better to encourage smoking cessation amongst lower SES groups. One solution is to consider carefully the implications of the ‘health’ message itself within health promotion. The research presented in Chapter Eight supports the notion that ‘health’ does not mean the same for all social classes (Blaxter, 1990; d’Houtard and Field, 1984; Pierret, 1983). For example, the higher SES

participants in this sample tend to prefer a definition of health-as-behaviour. Thus 'giving up for one's health' is somewhat of a tautology for middle-class smokers; smoking is, by definition, the opposite of health. It has immediacy about it, something to be acted on right now, whether or not the smoker is experiencing health problems. Lower SES participants, on the other hand, tend to prioritise a definition of general health which focuses on functionality. Thus many lower SES smokers classify themselves as healthy even though they smoke based on their ability to engage in everyday tasks. The encouragement to 'quit smoking for your health' may be interpreted differently by this group; one ought to stop smoking when one's functioning is severely compromised which may be when the effects are irreversible.

One potential solution is to focus on the short-term health improvements that can be made through smoking cessation. People who quit smoking often report having more energy, less breathlessness and a feeling of wellness once the initial quitting period is over (RCP, 2000). These are short-term concrete gains which will appeal to lower SES smokers as they do improve daily functioning, even though they may not be aware of any impairment beforehand. Both the lower and higher SES groups in this sample defined health as wellness and energy (health as enhancement), so this is a message which may appeal to both groups equally.

However, although there are perils in promoting a simple 'health' message regarding smoking cessation for different SES groups, there are equal perils in ignoring it. Risk-oriented health messages, as part of what has been termed the 'New Public Health Paradigm', have been strongly critiqued as stigmatising and individualistic (Petersen and Lupton, 1996; Skrabanek, 1994.) It has certainly been argued in this thesis that a biomedical risk-oriented model focusing on individuals' addiction to nicotine has become the dominant theoretical concept behind smoking cessation. The attempts to

counter-balance this, for example, through the ARISE (Associates for Research into the Science of Enjoyment) research group, have also been noted.

However, if the priority is to locate health promotion ‘where the audience is thinking’, one should not simply dismiss a biomedical risk-based model of smoking. The results in this thesis from both the interview and Q-sort study suggest this model has considerable resonance for how many smokers understand their smoking and relate to it in terms of their identity. That lay people should use a medicalized model as a prism through which to view smoking behaviour is not surprising. The critique of the NPH paradigm is precisely that it is so pervasive. Lay people’s understandings naturally reflect this dominance.

The solution is not to dismiss such a model, but rather consider carefully the implications of using it in a smoking cessation context. Clearly the account of smoking as nicotine addiction has resonance for both smokers and non-smokers who characterise smoking as compulsive. However, this account also carries with it connotations of helplessness and loss of control. This may be particularly problematic for lower SES groups who have lower perceived self-efficacy in the context of health (Chamberlain and O’Neill, 1998). One solution might be to emphasise that quitting smoking is achievable, even in the face of nicotine addiction. Some adverts in the ‘Testimonial’ campaign (www.givingupsmoking.co.uk/CNI/current-campaign) running concurrently with the ‘Ugly Smoker’ campaign in 2005/06 fulfil this brief. They feature ordinary people from all social classes who have used smoking cessation services and quit successfully. These positive messages provide images of people who will provoke a ‘like me’ rather than a ‘not me’ distancing response in the audience.

The results presented in this thesis also suggest that one should not think of the biomedical addiction model and other discourses as dichotomous alternatives. For

example, Graham (1994) has argued that single lone mothers tend to construct smoking as their sole luxury and coping mechanism rather than as a health risk. However, the results here show that often discourses such as pleasure run concurrently with those concerning health risk rather than as a substitute for them. For example, smokers who load onto the second identity (Factor Two) in the Q-sort, the 'not really a smoker' smoker, hold that smoking is both pleasurable and a risk to health. One needn't go as far as Klein (1993), who theorises that smokers find smoking 'sublime' precisely because it *is* dangerous, to acknowledge its paradoxical nature.

It is argued here that this paradox should be incorporated into health promotion. Acknowledging that smoking is, for many smokers, a source of pleasure does not necessarily have to prevent the delivery of a health message. Rather it situates health promotion not only where the audience is 'thinking', but where the audience is 'feeling'. By articulating this paradoxical experience, this may liberate the smoker from the sense that their enjoyment is a 'secret' reason not to quit. It would also allow them to consider how the loss of this pleasure might be compensated.

Another factor to consider for health promotion is the rapidly changing context of smoking identities. As argued in Chapter Eight, research into lay understandings and identities always reflects the socio-cultural context in which it is produced. This could be perceived as problematic, as such research could be considered historically bound and date quickly. However, another perspective might be to view this change positively. Such research tracks and highlights changes in social concepts over time. For example, Chapter Eight shows that the main definition of health for the middle-classes may have evolved since the research of Herzlich and Pierret in the 70's and 80's from 'health-as-wellbeing' to 'health-as-behaviour'.

The social context of smoking in England is undergoing a period of change. This will have implications for smoking identities and class. There will be a ban on smoking in enclosed public spaces as of 2007 (Department of Health, 2004; Health Committee, 2005). Similar or more stringent bans have already been implemented in Scotland, Ireland, Italy, New York and California amongst others. As argued in Chapter Six, the driver of this ban is the re-characterisation of smoking as a public health issue concerning the contamination of others, as opposed to a matter of personal choice for the self. Passive smoking has become a Health and Safety issue within the workplace. Government and employers are therefore required to protect their employees from this perceived risk.

This impending ban on smoking in workplaces/enclosed public spaces has several implications for smoking and class. Firstly, at a practical level, it will limit opportunities for smoking in a social context, such as bars, pubs and clubs. Middle-class smokers tend to have a more 'social', intermittent pattern of smoking (Jarvis & Wardle, 1999). Most professionals have had smoke-free working environments for some time. It is likely only to increase quit rates within this group. For working-class smokers, it will also represent a change. For those who perceive themselves as highly dependent, and are used to continual daily smoking, the challenge will be to go without smoking in working time as well as in social contexts. For a very heavily dependent minority, this may limit their job opportunities.

Secondly, at the social identity level at which this thesis is located, the identities of the smoker will inevitably change. The results presented in Chapter Five reveal that 'social' was the one major positive dimension of smoking identities. It is also one that tends to be associated with higher SES smokers, who, despite smoking at levels which would be classified as clinically dependent, often portray themselves as 'social' smokers. This

allows them to distance themselves from the more negative aspects of the ‘unhealthy, addicted, stressed’ smoker image. This understanding also allows them to attribute their smoking to external factors rather than their own internal compulsion. As the ‘social’ is taken out of ‘smoking’ and it becomes a private rather than public matter, these understandings will change. It is likely that smoking will become even more incompatible with other middle-class identities and that this, coupled with the practical restrictions on the contexts of much middle-class smoking, will cause rates in this groups to drop even further.

Indeed, the popular press has become fascinated by the possibility of the ‘demise’ of smoking. A report by the think-tank Future Foundation predicts that the number of smokers is ‘set to plummet’ from a quarter to fewer than one in ten within fifty years (Future Foundation, 2005). Several books have been published charting the decline of smoking, its rituals and etiquette as well as the erotic, emotional and cultural meanings (Sante, 2005; Klein, 1994). It seems a little too soon to say a final goodbye, however. There are still currently approximately 12 million smokers in the UK. Furthermore, the rapid downward rate from the 1950’s to the 1990’s in smoking has not continued. It has stabilised at around 25-27% of the population for the past five or more years (Lader & Meltzer, 2004). Other European countries and the US also have stable rates between 20%-30%. Some have suggested that this quarter of the population represent ‘hardcore’ smokers who are more heavily addicted and find it harder to quit (Jarvis et al., 2003).

In fact, it is arguable that what this ‘demise of smoking’ discourse represents is the ‘demise of smoking in the middle classes’ documented in the first chapter of this thesis. Sante (2005), for example, tells us ‘it’s true that in a few Western settings, student life, for example, or amongst fashion models, smoking remains almost normative’ (pp. 24). However, apart from these pockets of counter-culture, all the epidemiological evidence

shows smoking clusters with social disadvantage. What is more likely to happen is an exaggeration of the existing social pattern. Lower SES groups will continue to see a slower decline in smoking rates. This will in turn concentrate smoking in these groups, particularly the underclass, to the point where smoking itself will become a marker of disadvantage. People's poverty will be marked by their smoking. Indeed, the only people who will be able to smoke unrestrictedly all day will be those not at work, such as single mothers and the unemployed. The results from Chapter Six show that, for some higher SES non-smokers, smoking is already a marker of disadvantage and low educational achievement. The fact that the smokers in the Q-sort so vehemently react to the suggestion that smoking is linked to class shows this is a disadvantageous association to the smoker keen to protect their already devalued social identity.

It is also likely that the stigmatisation of the disadvantaged smoker will intensify. In Chapter Six, it was argued, following Stangor and Crandall's definition of stigma as 'peril' (2000), that smokers represent a combination of physical and symbolic threat. It was shown that pollution, principally the contamination of self and others, is a key metaphor through which smoking is understood. A ban on smoking in public places formalises and enshrines in law the notion that smokers contaminate others and that others have a 'right' not to be contaminated by them. This, coupled with a strong passive smoking lobby, is likely to increase people's sense of peril in the presence of smokers. Poor smokers in particular symbolise loss of control; they have, at many levels, the devalued identity of the powerless. It is important that smoking cessation approaches do not result in the further stigmatisation of the already stigmatised.

10.5 Contributions to the literature

This section considers the contributions which this thesis makes to the existing literature. It will be argued that it makes a distinct contribution in several areas.

What does this thesis add to the addiction literature?

It was argued in Chapter Two, that the primary conceptualisation of smoking in much of the health psychology literature reflects a dominant medicalised addiction model (Pomerleau & Pomerleau, 1984; 1989; West, McNeill & Raw, 2000). Even models of smoking cessation, such as the Transtheoretical model are predicated on the notion that one is changing an addictive behaviour (Prochaska, DiClemente and Norcross, 1992). It is important to note, however, that amongst lay people themselves, addiction only represents one amongst many ways of understanding ‘being a smoker’. Existing qualitative literature has aimed to unpack some of the understandings of ‘dependence’, ‘addiction’ and ‘habit’ in the lay population (e.g. Johnson et al., 2003, Amos et al., 2006; O’Loughlin et al., 2002; Moffat & Johnson, 2001; Bancroft et al., 2003; Laurier et al., 1999; McKie et al., 2002). This research was reviewed in-depth in chapter 2.2.6.

The research presented here both supports existing findings, and extends them. Research with adolescents has shown that they conceptualise dependence in terms of multiple functionality (e.g. Johnson et al., 2003), as do adults (Laurier et al., 1999; McKie, 2002). The findings here suggest that although addiction certainly represents a dominant discourse amongst lay people, from both higher and lower socio-economic backgrounds, it was not the only one, nor was it taken for granted. Rather it had the status of a ‘contested fact’. The interviews also highlighted a prevalent ‘drug language’ using addiction terminology not previously identified within lay talk. This may reflect the cultural narrative in the UK of smoking as a problematic addiction (Louka et al., 2006).

Existing research into notions of addiction in adults has been conducted primarily with smokers (Laurier et al., 1999; McKie, et al., 2002; Bancroft et al., 2003). It has shown that the use of addiction discourse is often rhetorical depending on the purpose of the

smoker. This was supported here; smokers from both SES groups often distanced themselves from the 'hard drug' end of the smoking continuum on the one hand, yet also used comparisons with hard drug use to show the difficulty of quitting. The interview findings here also suggest that non-smokers draw on the notion of addiction rhetorically, in ways which benefit their own social identity. Smokers are the subject of negative social comparisons, as dependent, 'out-of control' and 'selfish', with a strong moral discourse concerning harming others. They also identify the smoker as stressed and unable to cope. It is argued that, in the symbolic context of a Western Protestant culture which values self-control, discipline and achievement (e.g. Crawford, 1994), their self-identification as non-smokers, and thus non-dependent, demonstrates social identity work which reinforces and enhances their social status.

Previous research has suggested that disadvantaged smokers often understand their smoking in terms of 'coping' with their life circumstances (e.g. Graham, 1987; 1993a). The interview findings here suggest that smokers from both higher and lower SES groups understand their smoking in terms of stress-management. However, they do so in ways consonant with the symbolic contexts in which they inhabit. For example, the higher SES smokers in the interviews tend to emphasise their smoking as a functional, if unhealthy, coping strategy in a 'work hard, play hard' professional context, thus aligning themselves with the contemporary middle-class values described above (Crawford, 1994). The lower SES smokers, particularly the lower SES females, perceived smoking as a form of emotional coping with life-stress. The lower SES smokers also tended to use a 'harder' drug language concerning 'withdrawals', 'hits' and 'fixes' to explain their smoking, perhaps representing an internalisation of the medicalized addiction discourse. Gillies & Willig (1997) have suggested that the addiction discourse is dis-empowering; it is suggested here that this might particularly be the case for lower SES women.

Finally, the findings of the Q-methodology also add to the addiction literature. The largest factor, onto which over two-fifths of the smokers loaded significantly, was Factor One; the ‘Addicted, Unhealthy, Out of Control’ smoker. This adds support to the medicalization thesis concerning smoking (e.g. Penn, 1998; Gillies & Willig, 1997). Both lower and higher SES smokers loaded onto it, suggesting that it is a dominant filter through which smoking is viewed by lay people from all ends of the socio-economic spectrum. The dominance of this Factor in the Q-methodology study might reflect, to some extent, the nature of the research sample, many of whom (27%) were home-based either through caring responsibilities, long-term ill-health or unemployed with their corresponding highly dependent smoking patterns.

What does this thesis add to the health psychology literature?

Although stigmatisation is understood to be a key symbolic context in which health behaviour is situated (e.g. Campbell, 2005), and has been explored in detail in relation to health behaviours such as condom use and HIV/AIDS prevention (e.g. Joffe, 1995; 1996; 1999; Parker & Aggleton, 2003), little research has investigated the stigmatisation of smokers in Britain. This thesis has aimed to add to this literature by considering the symbolic, experiential and institutional basis of the stigmatisation of smokers in England, particularly in the context of the higher rates of smoking in lower SES groups (Farrimond & Joffe, 2006). The thematic analysis of the interviews presented in Chapter Seven identified several areas in which the stigmatisation of smokers is evidenced by the non-smokers: the existence of negative aesthetic ‘marks’ of smoking, the identification of smokers as ‘polluters’ who harm others, the displaying of direct and indirect social disapproval, and the association of smokers with ‘Other’ out-groups such as single mothers. Higher SES smokers tend to challenge the ‘facts’ on which this stigmatisation is based, whereas lower SES smokers may internalize the aspersions.

Recent British Tobacco Control campaigns, which play on the negative aesthetic of the smoker and the 'peril' which they represent, provide a symbolic context which may exacerbate stigmatisation. This may not have the intended motivating effect on lower SES groups who are already multiply stigmatized. It must be noted that this research took place at the end of 2001 and 2002, before wide-spread knowledge about the impending ban on smoking in England (on 1st July 2007). It is likely that understandings of smokers as representing 'peril' to others would be exacerbated by such legislation and this would be an interesting area for further research.

Another body of literature which this thesis might usefully add to is that concerning the health beliefs of smokers (e.g. Calnan, 1992; Chamberlain & O'Neill, 1998). This thesis goes further than simply outlining the differential class understandings of these health beliefs, by considering the socio-cultural valuation of health in late modernity (Crawford, 1994) as a key symbolic environment in which smoking identities are contextualised. This is particularly highlighted by the identification by the non-smokers in the interviews (of both SES groups) of the smoker as the 'Unhealthy Other'. As such, they define themselves, the non-smokers, as the 'healthy' and therefore responsible, self-disciplined and 'in control'. The findings from the higher SES smokers support previous research which suggests that smokers use a variety of rhetorical devices and strategies to mitigate their risk (e.g. Laurier, 1999; McKie et al., 2002). However, this thesis goes further than this to suggest that the 'health consciousness' of the middle-classes represents a fundamental clash of values which causes dissonance. Ultimately, giving up smoking offers middle-class smokers the opportunity to make their social identities more congruent. With respect to the lower SES smokers in the interview sample, they exhibited fatalism and powerlessness in relation to smoking-related health documented elsewhere (Lewis et al., 1989; Chamberlain & O'Neill, 1998). However, this thesis moves beyond these findings to show how, through making negative social

comparisons, and acceptance of their status as ‘at risk’, they appear to have internalised the designation of the smoker as the ‘Unhealthy Other’.

The Q-methodology findings also make a contribution in their own right. Only one previous Q-methodology study had investigated the understandings of adult smoking (Collins et al., 2002). This did not specify the socio-economic status of participants. They found that two of their factors, plus a significant portion of another, oriented around the ‘social’ aspect of smoking, which might suggest perhaps a young middle-class sample. This thesis extends these findings by specifically targeted lower SES smokers (42%) alongside higher SES smokers (58%). The Q-methodological study aimed to locate discrete ‘smoking identities’ amongst a sample of English smokers. A six-factor model of ‘smoking identities’ was generated. Three identities orient around a biomedical model of smoking as an addictive health risk; the ‘Addicted, Unhealthy, Out of Control’ smoker (Factor One), the ‘Not Really a Smoker’ smoker (Factor Two), and the ‘Ambivalent’ smoker (Factor Six). The other three reflect different understandings and values in the creation of smoking identities; the ‘Laissez-faire’ smoker (Factor Three), the ‘Proud’ smoker (Factor Four) and the ‘Stigmatized’ smoker (Factor Five). Each factor located in the Q-sort offers a coherent ‘understanding’ of being a smoker. It draws different aspects concerning values, functional behaviour, self-identity and wider socio-cultural perceptions into one ‘holistic’ identity rather than examining them as separate concepts.

Given that much of the research into smoking and identity has taken place with adolescents (e.g. Amos et al., 2006; Denscombe, 2001; Mitchell & Amos, 1997; Plumridge et al, 2002; Johnson et al., 2003), it is interesting to consider the Q-sort study of smoking identities in adults in terms of identity continuity and discontinuity. Certainly the proportion of smokers in this sample who self-identified at the addicted

end of the spectrum of dependence (2/5ths) is greater than, for example, amongst a sample of 16-19 year olds interviewed by Amos and colleagues (Amos et al., 2006). It is interesting to note, however, that the second factor, the 'Not Really a Smoker smoker' onto which many higher SES participants in their twenties loaded, bore much similarity to an 'ambivalent' identity found in adolescents (Amos et al., 2006). This suggests that there is much continuity between adolescent and early adulthood smoking identities. The continuity for middle-class smokers between their adolescent and adult smoking identities may reflect their 'slower' pathway to adulthood in comparison with the 'fast' track taken by lower SES young people (Graham & McDermott, 2005; Wiltshire et al., 2005).

What does this thesis add to the social psychological literature?

Although a significant body of research has investigated social identities in relation to smoking in adolescence (reviewed in Chapter 3.2.2), less research has considered smoking in adulthood from a social identity perspective (e.g. Collins et al., 2002; Echebarria-Echabe et al., 1994), particularly in relation to class. This thesis has taken a social psychological approach, therefore, to investigating 'smoking identities'. However, as discussed in Chapter One, despite the original characterisation of social identity as dynamic in relation to context (e.g. in the SCT of Tajfel & Turner, 1986), research using this paradigm has tended to subscribe to a de-contextualised notion of identity (Campbell, 1998). Furthermore, as Joffe & Staerkle (in press) have argued, social psychologists have tended to be concerned with identifying generic processes concerning social identity and comparison, rather than their actual content. Thus much research in this area lacks reference to contemporary values and culture.

This thesis therefore contributes to the literature by showing how the socio-cultural beliefs, myths and values of contemporary Western culture concerning control, health

and addiction (e.g. Crawford, 1994; Hammersely & Reid, 2002; Denscombe, 2001) as well as lay theories of poverty (e.g. Furnham & Gunter, 1984; Ryan, 1971) contextualise and make sense of the smoking identities. These have also been related to the social location of participants. As Denscombe has said, in relation to adolescent smoking identity formation, ‘smokers in the context of the health discourse of the late twentieth century run the risk of embracing an identity which, whatever it means to themselves and other smokers, is seen as bad by others’ (p.173). Thus, for example, in Chapter Six, I emphasised the symbolic content of stigma and the way in which it might reflect wider socio-cultural values which are also embedded at the institutional level. Similarly, the socio-cultural valuation of health in late modernity as a key symbolic context in which smoking identities are created was considered in the Discussion section of Chapter Eight.

It is also suggested that the Q-methodology used in the second study here might be a valuable tool to help uncover the counter or resistant identities in a culture, given the dominance of the health discourse. The interview study indicated that there are many aspects of smoking identities, such as rebelliousness, risk-taking, societal defiance and pleasure, which exist outside the dominant health discourse. However, although alluded to by many participants, it was clear that smokers felt some pressure to distance themselves personally from these aspects, or that they were bound by ‘political correctness’ in what is ‘sayable’ about smoking. Q-methodology may help articulate the ‘unsayable’ in several ways. Firstly, the statements already exist which makes these topics available and open for comment and reaction; the onus is not on the participant to raise them. Secondly, the Q-method analysis shows how these statements are ranked differentially across the factors. It is possible, therefore, to see whether some participants rank the statements neutrally, indicating sympathy for this viewpoint, whilst the majority strongly disagree. Finally, for pragmatic reasons this study was conducted

by post. This means that participants could rank statements and react to them in their comments without having to justify them immediately to a researcher, which as Laurier (1999) says, creates a problematic call to account for the smoker. This may produce more 'private' than 'public' accounts. Thus, three out of the six factors reflect alternative identities, and thus sets of values, beliefs and experiences, outside the dominant addiction model. Furthermore, the second factor, though not disputing the model, represented a distanced identity, the 'Not Really a Smoker' smoker. Alternative or parallel discourses, such as pleasure also featured in four of the factors. It is concluded, therefore, that Q-methodology offers a distinct methodological opportunity with which to assess the relation between dominant and alternative/resistant smoking identities.

Ultimately, this thesis has offered an exploration of smoking identities amongst different class groups in England as a starting point for future research. It is particularly hoped that public health approaches will not, consciously or unconsciously, exacerbate the stigmatisation of smokers. It is likely to be least effective where the most effect is desired; to reduce smoking rates amongst the disadvantaged.

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APPENDIX A:

STUDY MATERIALS

1. CONCEPTUAL MAP INSTRUCTIONS:

We are interested in the different images you have of smokers. Please list all the different images you have of a smoker using these boxes. Include everything you associate with one image into one box. Feel free to use both words and simple drawings to create each image. Don't worry how good an artist you are, a really simple drawing can be a great way of portraying your images. You can use a word more than once in different boxes. You do not need to use all the boxes, but add extra ones on the back of this sheet if you need them.

SMOKERS

Note: An identical format was used for the images of non-smokers

2. TOPIC GUIDE FOR INTERVIEWS

Conceptual map questions

The conceptual map is used as a discussion tool. Participants are asked to explain the images in more detail and relate them to personal experiences in their own lives. In addition, the following specific questions are asked:

Are there any groups of people that you associate with smokers?
Which of these images do you identify with yourself and why?

Main interview questions

For all questions participants were asked to think of specific examples or tell stories for their own lives to illustrate their answers.

Biography

What was your first experience with smokers/being a smoker?
When do smokers or smoking become an issue for you?

Meaning in everyday life

Can you tell me about your day yesterday and where and what part smoking played in it?
In your leisure-time, how are smokers/being a smoker part of that?
How is smoking/being a smoker in your family?
How is being a smoker in your work?

Giving up

What thoughts, feelings and images do you associate with the words 'giving up'?
Tell me about 'giving up' in relation to smoking for you?

Health

What thoughts, feelings or images do you associate with the word 'health'?
People do different things to maintain their health? What do you do and how does this relate to smoking?
How would you explain the link between smoking and health?
Who is at risk from the effects of smoking?

Addiction

What thoughts, feelings or images do you associate with the word 'addiction'?
How do you think smoking relates to addiction, if at all?

Abstract opinion

In your opinion, how is being a smoker thought of in society nowadays?

3. FINAL SET OF Q-SORT ITEMS (70)

1. Smoking is my only luxury
2. I sometimes think people forget that a lot of the great artists and musicians smoked
3. Smoking is really just a habit for me, something I do.
4. I feel powerless in the face of nicotine addiction.
5. When you get stressed, the first thing you do is reach for a cigarette
6. It is wrong to say that smokers can't be healthy; it all depends on the individual.
7. As long as people are adults, they should be left alone to decide if they want to smoke.
8. I sometimes think smoking looks quite sexy.
9. Smoking is one way of letting your hair down every now and again.
10. I do tend to associate smoking with poorer or less well-educated people.
11. Even though I am a smoker, I really don't like smoking
12. Being a smoker these days isolates you from your friends and colleagues.
13. There are many things I do to enjoy myself, and smoking is one of them.
14. I am more creative when I smoke
15. I don't think too much about why I smoke.
16. You may be addicted, but you should still try and do something about it
17. Smoking limits the type of life I would like to lead.
18. If I'm honest, there's a bit of me that still feels slightly rebellious when I smoke.
19. Smoking is a means of relaxation for me.
20. Smoking is just another habit like eating too much chocolate
21. It would be a struggle to quit, but I honestly feel that I could stop if I wanted to.
22. I'm a real worrier, which is one reason I smoke.
23. I think my smoking is very much down to people around me smoking.
24. Health is my number one concern in relation to my smoking.
25. If I feel my smoking getting out of hand, I tend to do something about it.
26. A little bit of me likes doing something a lot of people disapprove of, like smoking.
27. I think smokers in general tend to be a bit more individual than the next person.
28. Smoking is the only thing that I've got for myself.
29. People sometimes do think less of smokers, although they shouldn't.
30. Smokers are demonized these days, which is quite unfair.
31. I often feel disgusted at myself for continuing to smoke.
32. Smoking is a chance to escape for a while
33. Smoking should be seen as a medical addiction, just like drug or alcohol addiction.
34. I control my smoking, my smoking doesn't control me
35. Smoking helps me cope with life.
36. I know what the doctors say, but I sometimes feel that the risks of smoking have been exaggerated.
37. People worry too much about smoking; you could get run over by a bus tomorrow.
38. It sounds crazy to say it, but somehow the danger of smoking makes it seem a little bit exciting on some level.
39. Being seen as a smoker really doesn't bother me.
40. You are not a part of things if you don't smoke.
41. I like the fact that being a smoker puts you in a little club with other smokers.
42. Smoking is a dirty habit, whichever way you look at it.
43. One of the only times I get on my own is when I smoke
44. I think smoking is connected with having an addictive personality.
45. I'd have no problems stopping; I've done it quite a few times.
46. The lack of control is the worst thing about smoking
47. When you think about it, there are lots of things worse than smoking for your health.
48. The rights of smokers are increasingly ignored.
49. When I look around, smokers do seem to be more sociable than other people.
50. I think smoking looks down-market, even though I do it myself.

51. Stopping smoking would be like losing a best friend.
52. Most people are essentially tolerant of smoking, as long as it is not in their face.
53. I think the dependence aspect of smoking is exaggerated.
54. I feel like I will never quit smoking.
55. Neurotic people are far more likely to smoke.
56. I give a lot of thought to what cigarettes are doing to my health.
57. I smoke because life is short, and I want to live for today.
58. In general, I think smokers know how to enjoy themselves a bit more than other people.
59. I feel that to stop smoking would be to lose part of myself.
60. I don't really think my smoking affects the way I live my life.
61. People have a really negative perception of smokers nowadays.
62. One of the reasons I smoke is because cigarettes are a stimulant, they get you going when you need it.
63. I can't go without cigarettes for very long, I just can't do without them.
64. Smoking often has its roots in emotional problems
65. I'm aware when I'm smoking that it is a little taste of your own mortality.
66. No one group in society smokes, all types of people are smokers.
67. When I'm bored, the first thing I do is reach for a cigarette.
68. I'm definitely more laid-back than most non-smokers that I know
69. I agree with all these restrictions on smokers, after all, we are the ones in the wrong.
70. I wouldn't really call myself a smoker, more someone who smokes.

4. BOOKLET FOR Q-SORT

BOOKLET FOR SMOKING STUDY: FOLLOW EACH STEP

1. COMPLETE THE CARD SORT. In your envelope you will find a set of 70 cards. On each card you will find a statement, which you may or not agree with, about smoking. We would like you to spread out the cards on a large table or on the floor and arrange them according to how much you agree or disagree with each statement. Put the two statements you **most agree** with on the **far right**, then the two statements you **most disagree** with on the **far left**, then work inwards, so that eventually you end up with the same pattern as shown below. The middle is for neutral cards, which are cards about which you neither agree or disagree.

You will probably find it takes some time to move the cards around to show exactly what you think.

<i>MOST DISAGREE</i>						➡	<i>MOST AGREE</i>					
-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
2	3	4	5	7	9	10	9	7	5	4	3	2
cards	cards	cards	cards	cards	cards	cards	cards	cards	cards	cards	cards	cards

(Disagree)

(Agree)

When you are happy with how you have sorted the cards, please then write the number of each card into the corresponding position in the grid above, to record the order in which you arranged them.

Now turn over to the next page.

ANY QUERIES: CALL 07952 XXXXXX

2. CHOOSE THE STATEMENTS THAT WERE IMPORTANT TO YOU AND TELL US WHY. When you were sorting the cards, there may have been many statements that were important to you or you felt strongly about. We would like to know which ones these were and WHY. Take your time and write what you really think, as this is a very important part of the study.

I STRONGLY AGREED WITH...

Statement Number _____

The reason was.....

.....

.....

Statement Number _____

The reason was.....

.....

.....

Statement Number _____

The reason was.....

.....

.....

I STRONGLY DISAGREED WITH...

Statement Number _____

The reason was.....

.....

.....

Statement Number _____

The reason was.....

.....

.....

Statement Number _____

The reason was.....

.....

.....

These statements were also INTERESTING TO ME...

Statement Number _____

The reason was.....

.....

.....

Statement Number _____

The reason was.....

.....

.....

Statement Number _____

The reason was.....

.....

.....

Now turn to the last part of the study...

5. DEMOGRAPHIC AND SMOKING STATUS QUESTIONNAIRE**ANSWER THESE QUESTIONS.**

These are to help us know more about people's smoking habits and lifestyles. Tick one box for each question or write the answer in the space provided.

Q1. Are you... Male? ☐ Female? ☐

Q2. How old are you? _____

Q3. How many children do you have?

None ☐ 1 ☐ 2 ☐ 3 ☐ 4+ ☐

Q4. Please tick the one box which best describes how you spend most of your time.

☐ In paid employment (*go to question 5*) **OR**

☐ A full-time student ☐ Looking after home/family ☐ Retired ☐ Sick or disabled

Unemployed/other ☐
(*go to question 8*)

(NOTE: Only answer questions 5-7 if you are in paid employment).

Q5. What is the full title of your main job? (for example car mechanic, primary school teacher, benefits assistant)

Q6. Describe what you do in your main job.

Q7. What is the business of your employer at the place where you work? (for example making shoes, clothing retail, food wholesalers, doctor's surgery)

Q8. Do you work as an employee or are you self-employed?

☐ Employee ☐ Self-employed with employees ☐ Self-employed/freelance without employees (*go to Q11*)

Q9. How many people work/are employed at the place where you work?

☐ 1 to 24 ☐ 25 or more

Q10. Do you supervise any other employees on a day to day basis?

☐ Yes ☐ No

Q11. Were you born in the UK? Yes ☐ No ☐

If no, where were you born? _____

Q12. To which ethnic group do you consider you belong? (e.g. white, Black British) _____

Q13. Which newspaper do you usually read? _____

Q14. Which social class would you describe yourself as? _____

Q15. How old were you when you started smoking? _____

Q16. Over the past year, how many cigarettes do you usually smoke

a) in a day?

or

b) in a month?

Q17. How many times have you tried seriously to stop smoking over the past 5 years?

☐ Never ☐ Once ☐ 2-4 times ☐ 5 or more times

Q18. What is the longest time you have gone without smoking over the past 5 years? (not counting days that you were ill or in hospital)

☐ Less than 1 day ☐ 1-6 days ☐ 7 days to one month
☐ A month +

Q19. How much do you want to give up smoking altogether?

☐ ☐ ☐ ☐ ☐
Not at all Slightly Moderately Quite strongly Very

Q20. When do you smoke your first cigarette of the day after waking up?

☐ ☐ ☐ ☐
1 minute-30 minutes 30 minutes to 1 hour 1 to 2 hours More 2

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. ALL ANSWERS ARE KEPT CONFIDENTIAL AND ANONYMOUS (WITHOUT YOUR NAME ON THEM)

APPENDIX B:

CODING FRAME: DEFINITIONS AND OPERATIONALISATIONS

CODE NAME	DESCRIPTION	EXAMPLES
Functional narratives	Overall macro-narratives. They refer to the perceived functionality of cigarettes. Other codes are subsumed within them (e.g. personality-stress, work)	
Narrative-pleasure	Smoking is pleasurable or enjoyable	<i>'I haven't got a lot, why the hell should I stop smoking, it's the only pleasure I've got'</i>
Narrative-performance enhancing	Smoking enhances concentration or creativity	<i>'I find that I can have a flash of inspiration whilst I am outside smoking a cigarette'</i>
Narrative-time-marking	Smoking fills/passes time, is response to boredom	<i>'they don't seem to have an agenda for the day, they stand around gossiping and smoking'</i>
Narrative-stress-relieving	Smoking is stress-relieving	<i>'when you are under pressure, the first thing that you go for is a cigarette'</i>
Narrative-habitual activity	Smoking is a habit	<i>'they don't necessarily allow themselves to fall into that trap of getting into a habit'</i>
Emotions	Emotions personally felt by participants about smoking and smokers (not attributions of emotion to others)	
Emotion-calm	Feeling of calm, chilled or relaxation	<i>'a lot of people do it to relax, even to go into a trance state'</i>
Emotion-pleasure	Feeling of pleasure, enjoyment, buzz or comfort	<i>'I actually enjoy smoking...it is actually something you feel'</i>
Emotion-self-conscious	Feeling of being self-conscious or embarrassment	<i>'I am very conscious of it when I am out'</i>
Emotion-unpleasant	Unpleasant feeling	<i>'you are aware of the unpleasant effects that smoking has, the nasty taste in the mouth'</i>
Emotion-dislike	Feeling of dislike or hate	<i>'I dislike smokers'</i>
Emotion-fear	Feeling of fear, panic or fright	<i>'it's frightening' 'Panic, panic that you are going to die'</i>
Emotion-guilt	Feeling of guilt	<i>'sometimes you can end up beating up on yourself just for having that cigarette at all'</i>

Emotions-disgust	Feeling of disgust	<i>'especially if it is a woman, I find it quite disgusting'</i>
Emotion-misc	Miscellaneous emotion	
Social meanings/images of smokers	Social meanings of being a smoker. Primarily found in discussion of the conceptual map.	<i>Note: Most relate to the theme of control/release</i>
S-Personality-sociable	Smokers + social personality. If text mentions 'anti-social' code as 'dislike smoking'	<i>'smokers are sociable types'</i>
S-Personality-laid back	Smokers + laid-back, chilled, relaxed personality	<i>'I just think smokers are more chilled'</i>
S-Personality-inability to cope	Smokers + nervous, anxious, easily pressured, stressed personality	<i>'A lot of single mums tend to smoke for an emotional crutch'</i>
S-Personality-lack of aspirations	Smokers + lack of aspirations, desire to achieve	<i>'in general doesn't tend to have aspirations, is happy with the culture that revolves around smoking and people that smoke'</i>
S-Personality-laziness	Smokers + laziness	<i>'there's a perception oh this guy smokes, he's going to be nipping out every hour'</i>
S-Personality-lack of control	Smokers + lack of self-discipline, control or weakness	<i>'potential lack of self-discipline...almost a couch-potato view I think'</i>
S-Personality-negative other	Smokers' other negative personality attributions (e.g. arrogant, hostile, impulsive)	
S-Lack of self-care	Smokers + lack of self-care	<i>'you can't blow-dry your hair properly and smoke at the same time, can you?'</i>
S-Dirt/unclean	Smokers + dirt or uncleanliness	<i>'I think there is a general perception that smokers are dirty, because it is a dirty habit'</i>
S-Lower social status	Smokers + poverty, lack of education, broken families, class, unintelligent, deprivation	<i>'less educated as in haven't got any qualifications, tend to low skilled manual jobs to work in supermarkets'</i>
S-Margins of society	Smokers + illegality, criminality	<i>'it brings you into a whole seedy world you otherwise wouldn't be in touch with'</i>
S-Drug-alcohol	Smokers + alcohol, pubs	<i>'most of the people I know who enjoy a good drink or have a drink problem do smoke a helluva lot'</i>
S-Drug-illegal	Smokers + illegal drugs	<i>'then they go into 'E's and speed, but it does stem from smoking'</i>

S-Older	Smokers + ageing/look older	<i>'whether it is actually true or not, they look older'</i>
S-Youth	Smokers + youth/children	<i>'if you go into a bar of twentysomethings, the majority will be smoking'</i>
S-Unhealthy	Smokers + unhealthy	<i>'the ones I know, they tend to struggle with their health'</i>
S-Death	Smokers + death	<i>'he looked like a walking-corpse'</i>
S-Higher social status	Smokers + sophistication, glamour, success	<i>'smoking is always associated with cosmopolitan sophistication'</i>
S-other	Smokers + other social meanings (cool, rebellious, sad)	<i>'when you get older it is seen more and more as a sad thing'</i>
Social meanings/images of non-smokers	Social meaning of being a non-smoker. Primarily found in discussions of the conceptual map.	<i>Note: Most relate to the theme of control/release-esp lack of release</i>
NS-Personality-calm	Non-smokers + calm or relaxed personality	<i>'in their personalities they tend to be calmer, talk less fast, relax more'</i>
NS- Personality-ability to cope	Non-smokers + coping well with stress/life	<i>'they do tend to cope better'</i>
NS-Personality-stronger	Non-smokers + stronger, assertive or independent personality	<i>'maybe they've got stronger personalities, they didn't give in to peer pressure'</i>
NS-Personality-achievement/control	Non-smokers + greater achievement or control	<i>'achieve more with their time with their work and hobbies' 'more self-assured, more self-control'</i>
NS-Personality-lack of release	Non-smokers + lack of release, inc. too perfect, lack frailty, not laid-back, conventional, not risk-takers, boring	<i>'are they real?! Have they lives as adults at all? Do they have sex?'</i>
NS-Self-care	Non-smokers + taking care of self	<i>'the people I know that don't smoke tend to take more pride in their appearance'</i>
NS-Clean	Non-smokers + cleanliness	<i>'they tend to look cleaner'</i>
NS-Healthier	Non-smokers + healthier/look healthier	<i>'they do marshal arts and go swimming, maybe cos they do feel healthier'</i>

NS-Higher social status	Non-smokers + higher social status inc. intelligence, higher SES or class, professional jobs, better education	<i>'intelligence is linked to not smoking, to be honest'</i>
NS- Lack understanding	Non-smokers + lack understanding/tolerance	<i>'if you go shopping together... and you say 'oh shall we nip out for a fag?' they get annoyed'</i>
NS- Normative	Non-smokers as the norm	<i>'they are just normal people really'</i>
NS- other	Non-smokers + other social meaning	
Non-verbal signs of being a smoker	Non-verbal signs, functioning as both identifiers of smokers, also objects of disgust	
Smell	Smell of smoke	<i>'if you get on the bus and you sit next to somebody who smokes and you can smell that person is a smoker'</i>
Appearance	Appearance of smoker	<i>'you can tell by the way their finger are really yellow, til they turn sort of brown'</i>
Smoking signifiers and associations	Themes associated with smoking and cigarettes (not images of smokers)	
Expense	Smoking + expense	<i>'I said to them, pack up smoking and you might have a bit more, it's not the cheapest habit'</i>
Aging	Smoking + getting older/aging	<i>'when you are young you think you are going to live forever. As you get older... the cough starts'</i>
Gender	Smoking + gender esp masculine/feminine roles	<i>'it's a ladette thing...it's part of a real thing about equality'</i>
Sex	Smoking + sex	<i>'I associate it with sex, with people meeting'</i>
Mental illness	Smoking + mental illness	<i>'His backyard is covered with his cigarette butts and I can only think that it is linked to his state of mind'</i>
Death	Smoking + death	<i>'I'm dying for a cigarette!' 'Death-sticks' 'dicing with death'</i>
Pollution	Smoking + pollution or toxins	<i>'you wouldn't stand next to a bonfire, would you?'</i>
Unnatural	Smoking + nature, natural or unnatural	<i>'you don't see animals smoking do you? It's not natural'</i>

Control/self-discipline/achievement	Valuation of control/self-discipline and achievement in life in general and exhibited in the arena of smoking in particular. Note; all direct refs to control and health, code in health	<i>Note: A la Crawford. The tension is between control vs compulsion.</i>
Control-general	One values control/self-discipline in life in general	<i>'I think we all respect ourselves. That's not to say smokers' don't respect themselves, but...'</i>
Achievement-general	One values achievement in life in general	<i>'if you didn't smoke, you would have time to focus on better things to do in your life' 'I do achieve more than the smokers I know'</i>
Control-smoking behaviour	All refs to controlling smoking behaviour	<i>'I only smoked three yesterday, which was good'</i>
No control-smoking behaviour	All refs to inability to control smoking behaviour i.e. compulsive aspect of smoking (need, must, have to smoke)	<i>'I am dictated to by cigarettes' 'I have to have a cigarette' 'I will do whatever it takes to get a cigarette'</i>
Health definitions	Definitions and concepts of health	
Health-def-not ill	Health is the opposite of illness or the ability to do things (functional)	<i>'not having any problems with vital organs, lungs, heart ,etc'</i>
Health-def-well-being (ideal)	Health is a positive state of well-being (ideal)	<i>'energy' 'health is just a sense of well-being'</i>
Health-def-behaviour	Health is engaging in healthy behaviour	<i>'health, balanced diet'</i>
Health-def-other	Health is defined in other way	<i>'it's feeling normal really, I guess' it's down to luck'</i>
Health as a value	Valuation of health consciousness/healthiness in self and others	
Health-maintain	How one maintains ones health	<i>'all the smokers I know on 20 a day, you haven't got that big interest in food, you tend to skip breakfast, eat badly for lunch'</i>
Health-value	One is healthy esp. in relation to others who are unhealthy	<i>'I'm very physical even as a smoker' 'when I got fit I could do just as well as the people who weren't smoking, with breathing, with running, with everything'</i>

Health-responsibility	One needs to be responsible one's own health	<i>'they are very worried about the effects, they are saying 'I want you to be around to see my children'</i>
Health consequences	Descriptions of the physical consequences of smoking	
Health-effects	Health effects of smoking both general and specific illnesses	<i>'it's like killing yourself slowly''it causes bronchitis, hardening of the arteries, heart disease, cancers, premature aging, less energy, poor concentration'</i>
Health-own experience	Ones own experience of smoking-related ill-health	<i>'I got bronchitis because, I know, I'm a smoker!'</i>
Health-others experience	Other's experience of smoking-related ill-health	<i>'my father, he smoked Senior service untipped...he wasn't exactly fit'</i>
Health-invulnerability	One's invulnerability to the health effects	<i>'At the end of the day they say that smoking is not healthy for you. Personally I don't know whether I believe that or not'</i>
Health-misc	All other health discourse, inc. counter-themes here such as smoking not bad for you	<i>'it's harder to get other smokers to go to the gym, and if they do they don't stick at it'</i>
Addiction	Addiction narratives	
Addiction-spontaneous	All mentions of addiction prior to questions on the topic	<i>'it's an addiction, no doubt about it'</i>
Addiction-drug language	How one defines addiction	<i>'drug' 'addict' 'once you've had your fix, you do come down'</i>
Addiction-general definition	How one links smoking and addiction	<i>'loss of control, really, that's it' 'it's bad for the self'</i>
Addiction-smoking		<i>its addiction, it's something I constantly crave, the need for the nicotine.'</i>
Addiction-other drugs	One sees smoking as similar other addictions (or not)	<i>'giving up smoking is the same as what a heroin addict goes through'</i>
Addiction-misc	All other discourse on addiction	
Scientific discourse	Lay explanations of the science of smoking inc. addiction, nicotine, withdrawal syndrome, drug properties	<i>'the nicotine's like medication, if you don't take the medication, you start to feel the after effect of not taking it' 'they say it is actually more of a stimulant than a depressant'</i>
Politics	How smoking relates to gov't, business, cigarette manufactures	<i>'if I was to give up one of the major factors would be to kick the habit of consuming a product which was sold cynically by purveyors of'</i>

		<i>power.'</i>
Media	How smoking appears in media/publicity	<i>'there's more advertising about cancer now and my children associate cancer with cigarettes straight away now even if it isn't a cancer associated'</i>
Social nature of smoking	Association of social + smoking	
Social-locations	Smoking occurs in social places such as pubs, cafes	<i>' the pub, that's smoker's paradise, isn't it'</i>
Social-triggers	Smoking is triggered by other people	<i>'put simply, seeing people smoke makes you want to smoke more'</i>
Social-bonding	Smoking is a shared experience, something in common	<i>' there's a bond, an understanding that you need that drug'</i>
Social-tool	Smoking is a useful social tool e.g. to cover embarrassment, as an extension of self, as a chat up line.	<i>'people use it to point...it is as if it is almost an extension of them'</i>
Social-rules	Smoking has social rules within the group e.g. reciprocity	<i>'you know it is going to be reciprocated, because as a smoker you get annoyed if someone is just taking'</i>
Social knowledge	Awareness and negotiation of internal (unwritten) and external rules on legitimate smoking	<i>Note: knowledge of internal rules may function to show acceptance of the dominant view of smoking as 'bad' esp. in contested spaces</i>
Norms-spatial	Smoking norms in the street/road, houses, restaurants (unwritten)	<i>'its almost an unwritten law that you will go outside'</i>
Norms-avoid harm to others	Smoking norm to avoid harming others e.g. during pregnancy	<i>' If I fell pregnant again I wouldn't smoke, that would be something, I wouldn't smoke, I wouldn't do that'' I smoked with both of mine, it wasn't out then, it wasn't a big thing then'</i>
Limits-time	Smoking limits available time	<i>'a helluva lot of time is taken up smoking'</i>
Limits-places (except work)	Smoking limits where you can go	<i>'I constantly avoid no-smoking places, so it does affect my life'</i>
Limits-work	Smoking limits exist at work	<i>'it had a no-smoking policy and I smoked and I let other people smoke and they kept telling me off cos it was against the law'</i>
Early experiences	One's first/early experience of smoking or smokers	<i>'god, the first time I tried was really awful'</i>
Social change	How attitudes/experiences have changed for smokers in recent	<i>'when we were smoking years ago there was no problem with</i>

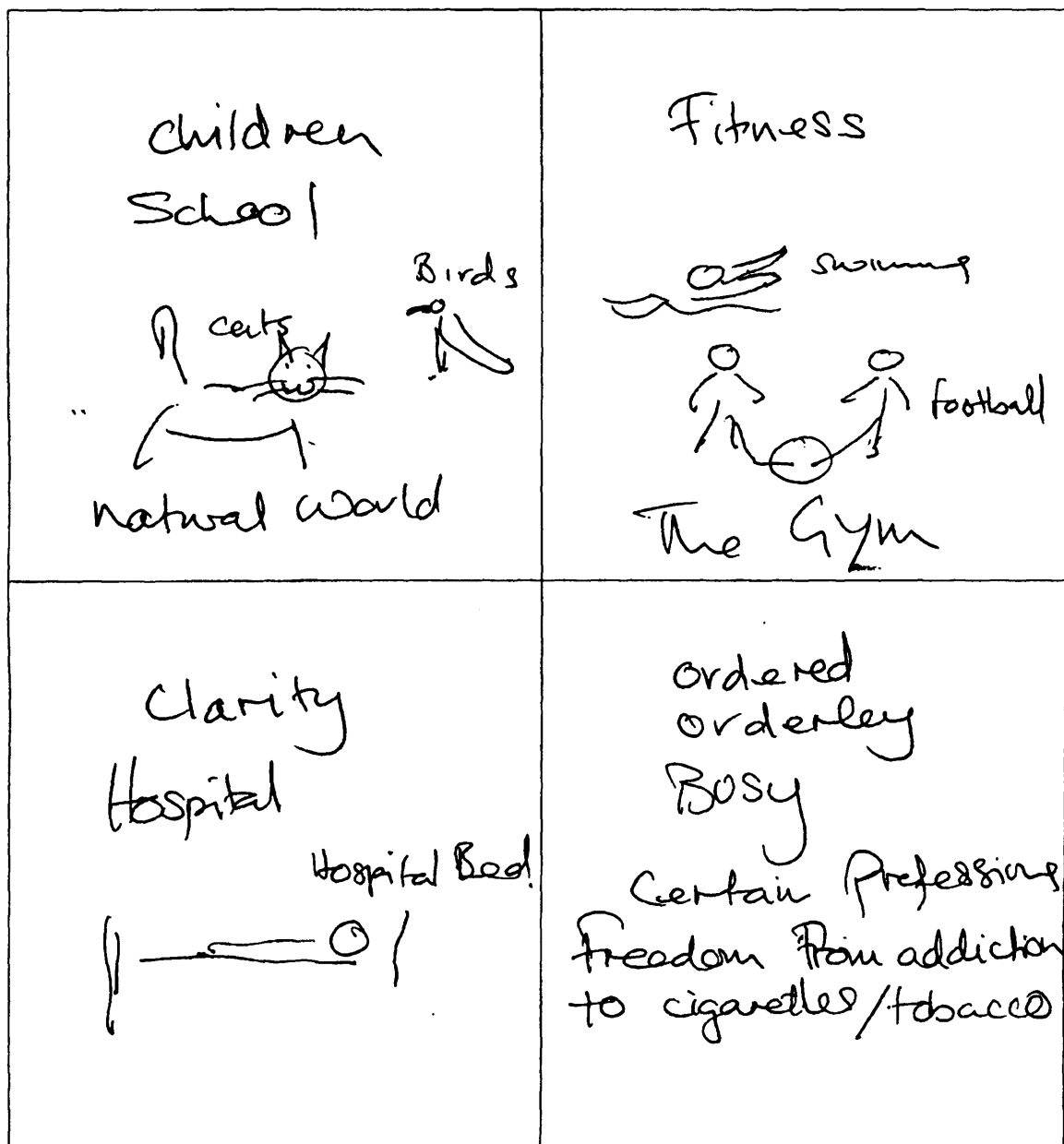
	history	<i>smoking, people didn't start acting like they were choking'</i>
Family smoking	One's family + smoking	<i>'some of my relations are heavy smokers, I don't smoke, I never have'</i>
Social Identity	Social identity processes at work when people identify with or reject the identities of being a smoker or a non-smoker (Note: except healthy identity which is coded in health)	
SI-defines	Smoking can/cannot be used to define people's identity and status (in general)	<i>'I think less of the smokers. I'm a little less respectful, which is awful'</i> <i>'I see myself as someone who smokes rather than as a smoker'</i>
SI-classification	Types or classification of smokers (e.g. social, heavy)	<i>'I know social smokers and people who are addicts, like myself'</i>
SI-social comparison positive	One makes a positive social comparison (i.e. myself or my group is better)	<i>'my family and friends for what reason seem to take physical health more seriously...and the other set are at the other end of the spectrum'</i>
SI-social distancing	One distances oneself from the group or identifies them as 'other'	<i>'even though I am a smoker myself, I would never...'</i> <i>'I'd say I had a lot in common with a non-smoker'</i>
SI-self-identity	One personally identifies or doesn't identify with being a smoker	<i>'I hate that part of me because I am a strong personality, hate the fact that I am dictated to by cigarettes'</i>
SI- minority	One sees smokers as having minority, out-group or outcast status	<i>'smokers are becoming the minority now and I think it is a persecution thing' 'we are outcasts'</i>
Smoking cessation	Conceptualisation of smoking cessation	
Cessation-experiences	Descriptions of cessation experiences (self or others) inc. withdrawal, loss	
Cessation-willpower /achievement	Cessation + willpower, achievement or other positive qualities	<i>'bravery, determination, admiration, it's clearly a difficult thing to do' 'it needs willpower'</i>
Cessation-identity change	Cessation changes one's identity	<i>'I would be a whole different person if I gave up'</i>
Cessation-social isolation	Cessation causes isolation from the social group	<i>'I seen her reaction when I said I wanted to give up, I think she's scared my circle of friends might'</i>

		<i>change'</i>
Risk to others	Theme concerned with harm to others, especially 'innocents.' May overlap with norms-avoid harm to others	
Risk-passive smoking	Risk of passive smoking	<i>'from what I've seen on TV, the effects of smoking are more serious for a non-smoker inhaling it, secondary smoke'</i>
Risk- children/babies	Risk to children, babies, foetus	<i>'That's putting your own personal needs which are clearly unarguably unhealthy before that of an unborn child'</i>
Social disapproval	Disapproval or social dislike based on smoking status, either as object or perpetrator	
Implicit disapproval	Implicit or covert social disapproval (e.g. being anti-smoking)	<i>'they are very anti-smoking' 'I had drips hanging out of me, I could barely stand up, but the look of disgust'</i>
Explicit disapproval	Explicit or overt challenge to smoker	<i>'someone quite loudly objected to the fact that I'd blown a load of smoke out and he'd had to inhale it'</i>
Rejection of disapproval	Defence/rejection/reaction to disapproval	<i>'I wasn't going to be spoken down to as a smoker'</i>
Rights/responsibilities	Values used to express support/disapproval of smoking and smokers	
Rights/freedom/equity	Individuals have rights, freedom or equity to smoke or avoid smoke	<i>'I would have left the job if I felt like I couldn't have the freedom to have a cigarette'</i>
Disclaimers	One should be non-judgemental or liberal or only speak for oneself	<i>'everyone is entitled to smoke, it's a free country' 'that's just my opinion'</i>
Moral judgement	Moral judgements or statements about smokers/smoking	
Selfish	One is selfish in relation to smoking	<i>'it's a selfish thing because everybody is aware of what your smoke does to them'</i>
Judgemental	One is judgemental in relation to smoking	<i>'totally hypocritical, I know, but all this judgemental stuff comes in, you always try to put them in a group of some sort, so smoking is one group, seen as bad'</i>
Overall misc	Looks important but not appropriate code	

Reaction to task	What one thought of the conceptual map or interview	<i>'I'm not sure I would say the same thing if you asked me again tomorrow'</i>
Style of talk	Significant conversational features (e.g. acceptance of the dominant social position)	'their's is a superiority complex, it's like 'tut', I've given up. Absolutely, it's quite a good thing to be free of it, but I like smoking'

APPENDIX C: EXAMPLES OF CONCEPTUAL MAPS^{p8}

NON-SMOKERS





A. Conceptual map of Higher SES non-smoker, aged 40-60 years old

APPENDIX C

CONCEPTUAL MAP

INSTRUCTIONS: We are interested in the different images you have of smokers. Please list all the different images you have of a smoker using these boxes. Include everything you associate with one image into one box. Feel free to use both words and simple drawings to create each image. Don't worry how good an artist you are, a really simple drawing can be a great way of portraying your images. You can use a word more than once in different boxes. You do not need to use all the boxes, but add extra ones on the back of this sheet if you need them.

SMOKERS

<p>ONE FOR THE ROAD,</p> 	<p>THE THINKER.</p> 


B. Conceptual map of Lower SES smoker, aged 40-60 years old

APPENDIX C

PA

INSTRUCTIONS: We are interested in the different images you have of smokers. Please list all the different images you have of a smoker using these boxes. Include everything you associate with one image into one box. Feel free to use both words and simple drawings to create each image. Don't worry how good an artist you are, a really simple drawing can be a great way of portraying your images. You can use a word more than once in different boxes. You do not need to use all the boxes, but add extra ones on the back of this sheet if you need them.

SMOKERS

 <p>smelly clothes & - breath</p>	<p>i know the image i'm doing but just have to have a bag!</p>
<p>i won't die if i smoke it's always someone else he he!</p>	<p>i may not live 95 long but i'll be happier smoking than not and being boring? x</p>

C. Conceptual map of Lower SES non-smoker, aged 40-60 years old



CONCEPTUAL MAP

INSTRUCTIONS: We are interested in the different images you have of smokers. Please list all the different images you have of a smoker using these boxes. Include everything you associate with one image into one box. Feel free to use both words and simple drawings to create each image. Don't worry how good an artist you are, a really simple drawing can be a great way of portraying your images. You can use a word more than once in different boxes. You do not need to use all the boxes, but add extra ones on the back of this sheet if you need them.

SMOKERS

<ul style="list-style-type: none"> - SELFISH - INCONSIDERATE LOVE OF OTHERS UNWARY - ON UNAWARE OR DON'T CARE ABOUT HOW THEIR HABIT AFFECTS OTHERS. THINKING - ARROGANT 	<ul style="list-style-type: none"> - WEAK MINDS WASTEFUL - STUPID - DOING SOMETHING THAT SO OBVIOUSLY HARMS THEMSELVES AND OTHERS IS NOT VERY INTELLIGENT. - ADDICTIVE PERSONALITIES <ul style="list-style-type: none"> - DRINKERS - GAMBLERS - DRUG USERS
<ul style="list-style-type: none"> - WORKING CLASS - POOR - POORLY EDUCATED DRUNK - MORE INCLINED TO BE FOLLOWERS "SHEEP" - EASILY LED, NOT STRONG WILLED OR INDIVIDUALISTIC. 	<ul style="list-style-type: none"> - LITTLE AWARENESS OF HOW THEIR BODY IS AFFECTED BY THEIR HABIT <ul style="list-style-type: none"> - BAD SKIN - BAD TEETH - PREMATURE AGING - ILL HEALTH - EVENTUAL DEATH - POOR HEALTH - CANCER.

D. Conceptual map of Lower SES smoker, aged 20-40 years old

APPENDIX C

INSTRUCTIONS: We are interested in the different images you have of smokers. Please list all the different images you have of a smoker using these boxes. Include everything you associate with one image into one box. Feel free to use both words and simple drawings to create each image. Don't worry how good an artist you are, a really simple drawing can be a great way of portraying your images. You can use a word more than once in different boxes. You do not need to use all the boxes, but add extra ones on the back of this sheet if you need them.

SMOKERS

<p>Old man roll up tobacco heavy cough sitting on a park bench Miserable!</p> 	<p>Youthful girl attractive How come she isn't affected by smoking so much?!</p> 
<p>Someone standing for a bus, nothing to do, so light up a fag</p> 	<p>In a crowd, need to impress, (although no-one is impressed! Although at least it keeps you awake while drinking. Next day they feel like shit and decide to give up (for 5 hours).</p>

E. Conceptual map of Higher SES smoker, aged 20-40 years old.

APPENDIX D:

ETHICS DOCUMENTS

I This research was conducted (in 2001/2002) under the remit of a wider study into Latent drivers of images of oral health, which received ethical approval from the (now defunct) Joint UCL/UCLH Committees on the Ethics of Human Research. I have included a copy of the original Ethics Approval Form for that study, headed by Helene Joffe (Ref 01/0070) (E4). UCL ethical guidelines were followed with respect to consent and data protection.

II In 2003, the new UCL Ethics Committee was formed and PhD students were required to submit a separate application for their own studies unless exempt. As a human participation study involving interviews/surveys with non-sensitive participants, this research falls under exemption 'c' specified by the UCL Committee (<http://www.grad.ucl.ac.uk/ethics/exemptions.php>) so did not require full Ethics approval by the UCL committee (it also would have been retrospective at this point as the data collection was complete). I have included a copy of the exemptions below (E5).

III UCL ethical guidelines were followed with respect to consent and data protection. Participants were given a Participant Information Sheet (which they could take home), an Ethical Consent Form which was signed and a Subject receipt form for payment (£5 for the interview study and £15 for the Q-methodology study).

These documents are kept in a locked filing cabinet at UCL in accordance with the Data Protection Act. The original tape-recordings of the participants are anonymous so that the participant can only be identified by the participant number. Similarly the anonymous transcripts, all transcribed by Hannah Farrimond, are stored in password protected computer files. Examples of these documents are shown below (E1, 2 & 3).

D.1 Information sheet for interview participants



Department of Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET, LONDON WC1E 6BT

CONFIDENTIAL

Study Title: 'An investigation into people's images of smokers and non-smokers'

Names of investigators: Helene Joffe and Hannah Farrimond

Information Sheet for Volunteers

Volunteers are invited to take part in a study looking at people's images of smokers and non-smokers.

To take part, you will complete a short task which asks you for your first thoughts/images about smokers and non-smokers and to put these down on paper. You will be left alone for 10 minutes to do this. Don't think too carefully, just put down what comes into the top of your head. You can use words or pictures or both to create your images! After that you will undertake an interview which will ask you about your thoughts, feelings and experiences in relation to the topic. You will also complete a short questionnaire. This will take about 45 minutes to one hour, either at the University or at your home, as you prefer. To reimburse you for your time, we will give you £5. (UCL participation research rate at £5 an hour)

You should note that throughout the study that there are no right or wrong answers; we are interested only in what *you* think about smokers and non-smokers, and in the ideas and images you associate with them. We will tape-record and later transcribe your interview, and would like to keep the images you produce. However, any information or answers you give will be used for research purposes only, will be made anonymous and treated as confidential. If you have any queries at all about the study or what will be expected of you please feel free to ask.

Please note that you do not have to take part in this study if you do not want to, and if you decide to take part you may withdraw at any time without having to give a reason. You will find a consent form attached. As a part of normal research ethics we would be grateful if you would complete this form, and retain this information sheet for your own reference.

D.2 Information sheet for Q-sort participants*Department of Psychology***UNIVERSITY COLLEGE LONDON****GOWER STREET, LONDON WC1E 6BT****CONFIDENTIAL****Study Title:** 'An investigation into people's images of smokers and non-smokers'**Names of investigators:** Helene Joffe and Hannah Farrimond**Information Sheet for Volunteers**

Volunteers are invited to take part in a study looking at people's images of smokers and non-smokers.

To take part, you will receive a pack by mail containing an information sheet, consent form, a booklet containing a grid and a pack of 70 statements. You will also receive a name and address label which you must fill in and return to receive your payment. The task will take about 45 minutes to one hour, to be completed at home by you. You will read through the 70 statements about the images of smokers and non-smokers, then sort them into piles about which you 'agree' 'disagree' or are neutral. Using these piles as a guide, you will sort them into the pattern shown on the grid and write the number down. You will then explain why you agree or disagree with some of your statements. Finally you will fill in a short questionnaire. To reimburse you for your time, we will give you £15.

You should note that throughout the study that there are no right or wrong answers; we are interested only in what *you* think about smokers and non-smokers, and in the ideas and images you associate with them. However, any information or answers you give will be used for research purposes only, will be made anonymous and treated as confidential. If you have any queries at all about the study or what will be expected of you please feel free to ask.

Please note that you do not have to take part in this study if you do not want to, and if you decide to take part you may withdraw at any time without having to give a reason. You will find a consent form attached. As a part of normal research ethics we would be grateful if you would complete this form, and retain this information sheet for your own reference.

D.3 Consent form for all participants*Department of Psychology***UNIVERSITY COLLEGE LONDON****GOWER STREET, LONDON WC1E 6BT****CONFIDENTIAL****Study Title:** 'An investigation into people's images of smokers and non-smokers'**Names of investigators:** Helene Joffe and Hannah Farrimond**Consent Form for Volunteers**

- | | |
|---|-----------------|
| Have you read the information sheet about this study? | <i>Yes / No</i> |
| Have you had an opportunity to ask questions and discuss this study? | <i>Yes / No</i> |
| Have you received satisfactory answers to all your questions? | <i>Yes / No</i> |
| Have you received enough information about this study? | <i>Yes / No</i> |
| Do you understand that you are free to withdraw from this study at any time, and without giving a reason for withdrawing? | <i>Yes / No</i> |
| Do you agree to take part in this study? | <i>Yes / No</i> |

SIGNED

DATE:

PRINT NAME

INVESTIGATOR

SIGNED

DATE:

D4: Copy of original approval for wider study on Aesthetics and Oral Health



The University College London Hospitals
The Joint UCL/UCLH Committees on the Ethics of Human Research

Committee A Chairman:

Please address all correspondence to:

Research & Development Directorate
UCLH NHS Trust

Department of Psychology
UCL
Gower Street

April 9, 2001

Dear Dr

Study No: 01/0070 (*Please quote in all correspondence*)
Title: What are the latent drivers of oral hygiene

Thank you very much for letting us see the above application which was reviewed by the Chairman and agreed by Chairman's Action. There are no objections on ethical grounds to this study going ahead

Please ensure that you have obtained final approval from the Trust (via the R&D office) before proceeding with your research.

Please note that it is important that you notify the Committee of any adverse events or changes (name of investigator etc) relating to this project. You should also notify the Committee on completion of the project, or indeed if the project is abandoned. **Please remember to quote the above number in any correspondence.**

Yours sincerely

Chairman

/in/April 9, 2001

University College London Hospitals is an NHS Trust incorporating The Eastman Dental Hospital, The Hospital for Tropical Diseases, The Middlesex Hospital, The National Hospital for Neurology & Neurosurgery, The United Elizabeth Garrett Anderson Hospital and Hospital for Women, Soho, and University College Hospital.

D5: UCL Research Ethics Committee Exemptions

Taken from (<http://www.grad.ucl.ac.uk/ethics/exemptions.php>) on 1st November 2006

All research proposals involving living human participants and the collection and/or study of data derived from living human participants undertaken by UCL staff or students on the UCL premises and/or by UCL staff or students elsewhere → requires ethical approval to ensure that the research conforms with general ethical principles and standards UNLESS the only involvement of human participants in particular research activities will be in one or more of **categories a - e** (→ exemptions), in which case the research will be exempt from ethics approval unless approval is specifically required by an external funding body or other external body in order to obtain research permission'.

Exemptions

If research is exempt from formal approval under the following criteria, it is still expected that UCL researchers will abide by their appropriate disciplinary ethical guidelines. → Useful Links.

In accordance with the following criteria, Department Heads have final judgement as to whether a particular activity should be exempt from the requirement for approval by the UCL Ethics Committee. But note that the exemptions below do not apply to research involving vulnerable participants (e.g. mental patients, prisoners), fetuses, pregnant women or human in vitro fertilization. Note also that exemption (b) does not apply to research on children except when the investigator(s) do not participate in the activities being observed.

Exemption from approval by the UCL Ethics Committee DOES NOT IMPLY that the research is also exempt from registration with the UCL Data Protection Officer. If you are in doubt about Data Protection requirements, please consult the → UCL Records Office website for further information.

The following types of human participant research DO NOT require ethics approval:

- a. Research involving the collection or study of EXISTING data, documents or records that are publicly available. For example, published biographies, newspaper accounts of individual's activities and published minutes of a meeting would not be considered 'personal data'.
- b. Research involving anonymised records and data sets that exist in the public domain, for example, datasets available through the office for National Statistics where appropriate permissions have already been obtained and where it is not possible to identify individual from the information provided.
- c. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behaviour UNLESS information obtained is recorded in such a manner that human participants can be identified AND any disclosure of the human participants' responses outside the research could reasonably place the participants greater at risk of criminal or civil liability or be damaging to the participants' financial standing, employability, or reputation.
- d. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behaviour that is not exempt under paragraph (b) of this section, if the human participants are elected or appointed public officials or candidates for public office.
- e. Taste and food quality evaluation and consumer acceptance studies, if wholesome foods without additives are consumed, OR if a food is consumed that contains a food ingredient at or below the level and for use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe by the appropriate government regulators.

APPENDIX E:

VIGNETTES OF A SAMPLE OF INTERVIEW PARTICIPANTS

P19. Smoker, Lower SES

This smoking participant was a single mother ('working' class*), white, with two teenage boys. She had a partner who worked. She lived on a council estate in Camden, near a tube station with buses into Central London. Although she acknowledged that there was 'crime' and people doing drugs on the estate, she also felt there were many people 'like her' on the estate who were trying to better themselves. She worked as a part-time cleaner and also claimed Working-Tax credits. She smoked 20 a day. She had had a hysterectomy and had ongoing related health problems. She wanted to quit smoking, and had sent off for a form from the Smokers' Clinic (where she was recruited), however, she never followed it through. She smoked within 30 minutes of waking.

P35. Smoker, Lower SES

This smoking participant was a 'working-class' white male aged 24 who worked as a gym receptionist in Central London (recruited alongside P39 detailed below). He commuted in daily from a suburb of London. He had no children, but a large group of friends who 'know how to live it large' with whom he smoked on weekends. They engaged in recreational drug use. He had not tried to quit. He smoked '15' on weekend nights, but less in the week, 'tanking up' before going into work. He smoke within 30 minutes of waking, and several of the evening cigarettes were cannabis joints smoked alone or with his girlfriend.

P1. Smoker, Higher SES

This white female smoker ('lower middle'), aged 23, worked in a science department at a London University and was recruited through the Participant Database at UCL. She was doing a Masters, and commuted in daily from Essex, where she lived with her parents in their large house with a garden. She worked 'part-time' in a bar on weekends. She had no children. She smoked 3 a day, but said that it could vary, smoking more on weekends. She had quit for periods of time, during 'healthy periods' in her life but was currently smoking. She smoke two hours after waking.

P11. Smoker, Higher SES

This male smoker ('middle-class'), aged 33, worked in Central London and was interviewed in a quiet room in his office block. He was recruited through a circular email to his company from another participant. He did not have any children. He had quit in the past for two years, however, he had fallen into what he described as a 'black, dark depression' and started smoking again. He smoked 10-15 a day, although the office was non-smoking, so he needed to go outside or smoke outside work hours. He smoked within 30 minutes of waking.

P29. Non-Smoker, Higher SES